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NEOMYCIN THERAPY

ITS USE IN VIRUS PNEUMONIA, TUBERCULOSIS AND DISEASES CAUSED BY GRAM-NEGATIVE BACTERIA

Elmer R. Kadison, M.D.
*Italo F. Volini, M.D.**
Samuel J. Hoffman, M.D.
and
Oscar Felsenfeld, M.D., Chicago

Neomycin, an antibiotic isolated by Waksman and his associates [1] from Actinomyces fradii, was tested by its discoverers against selected organisms and by our group [2] against 370 strains of bacteria, viruses and protozoa in vitro and in experimental animals. The average inhibitory concentration of neomycin expressed in units per cubic centimeter of test medium in vitro was 0.1 for Listeria, 0.9 for Salmonella typhosa, 0.16 for paratyphoid bacilli, 1.3 for other Salmonella, 1.0 for Shigella, 0.44 for Escherichia, 1.9 for Aerobacter, 1.8 for Klebsiella, 1.05 for Proteus, 3.1 for Pseudomonas, 0.8 for Brucella, 0.12 for Pasteurella, 0.4 for cholera vibrios, 0.1 for Mycobacterium tuberculosis, 0.15 for Treponemataceae and 4.7 for Endameba histolytica; the range of activity varied from doses equivalent to approximately one tenth of the average to about twenty times higher concentrations. Neomycin was active against both streptomycin sensitive and streptomycin resistant tubercle and typhoid bacilli. Gram-positive cocci and clostridia did not respond too favorably to neomycin, while the group of enteric bacteria was uniformly checked by appropriate doses of neomycin. Thus in this group neomycin differed from chloramphenicol (chloromycetin®) and aureomycin by inhibiting also Pseudomonas and from the polymyxins by acting also on Proteus. Judging from experiments with only one strain,[2c] neomycin did not seem to be valuable for the treatment of Hemophilus influenzae and Neisseria meningitidis infections. Recent experience, however, required a revision of this statement. Trials with seven strains of H. influenzae isolated from cerebrospinal fluids showed that neomycin is active also against this bacterium in concentrations of 3.12 to 6.25 units per cubic centimeter of liquid test medium, while 0.35 to 0.9 micrograms of chloramphenicol, 1.56 to 12.5 micrograms of aureomycin or 3.12 to 25 micrograms of streptomycin were necessary to achieve a bacteriostatic effect under identical conditions. Four strains of N. meningitidis from cerebrospinal fluids were also inhibited by 3.12 to 6.25 units of neomycin per cubic centimeter of culture medium. On the other hand, 53 strains of molds and yeasts were not checked by highly purified neomycin. The favorable action of neomycin on many organisms raised the hope that it may be of value in medicine.

Neomycin [3] showed little toxicity in mice.[4] Amounts equivalent to 40,000 units per kilogram of weight injected intraperitoneally were well tolerated by these rodents. Furthermore, experiments on Macaccus monkeys showed that 5,000 units per kilogram of weight injected three times a day intramuscularly for two weeks did not cause clinical symptoms or histologically detectable damage of the kidneys, the liver or other organs. Thus it was decided to use neomycin also in man.

Preliminary studies [5] showed that neomycin injections in man cause a rapidly rising blood level. At least 200 units per kilogram of body weight had to be given to achieve a level of about 1 unit per cubic centimeter of blood. Five hundred units per kilogram produced an initial blood level of 2 or more units, which descended to 0 in about eight hours. Injections of 1,000 units per kilogram caused a slightly longer lasting level, which varied during the first four hours between 2.5 and 20 units. Neomycin was excreted through the kidneys, the two hour urinary level being approximately 7 units after the injection of 200 units and about 40 units after the injection of 350 to 500 units per kilogram of weight.

Neomycin was made available to us in the form of its soluble sulfate salt. In order to maintain a favorable blood level, the amount to be given per day was divided into three, later into four equal doses. The drug was injected intramuscularly or applied locally.

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* Dr. Volini died on June 24, 1950.

From the Hektoen Institute for Medical Research of the Cook County Hospital.

1. (*a*) Waksman, S. A., and Lechevalier, H. A.: Neomycin, A New Antibiotic Active Against Streptomycin-Resistant Bacteria, Including Tuberculosis Organisms, Science **109**: 305, 1949. (*b*) Waksman, S. A.; Frankel, J., and Graessle, O.: The in Vivo Activity of Neomycin, J. Bact. **58**: 229, 1949.
2. (*a*) Ishihara, S. J., and Felsenfeld, O.: Action of Neomycin on Protozoa, J. Parasitol. **35** (Dec. supp., pt. 2): 33, 1949. (*b*) Felsenfeld, O.: Volini, I. F.; Ishihara, S. J.; Bachman, M. C., and Young, V. M.: A Study of the Effect of Neomycin and Other Antibiotics on Bacteria, Viruses, and Protozoa, J. Lab. & Clin. Med. **35**: 428, 1950. (*c*) Felsenfeld, O.; Volini, I. F.; Young, V. M., and Ishihara, S. J.: Laboratory Tests with Newer Antibiotics on Microorganisms Commonly Prevalent in the Tropics, Am. J. Trop. Med. **30**: 499, 1950.
3. Neomycin was supplied to us by the Commercial Solvents Corporation, Terre Haute, Ind.
4. Waksman,[1b] Ishihara,[2a] Felsenfeld.[2c]
5. Felsenfeld, O.; Volini, I. F.; Kadison, E. R.; Zimmermann, E., and Ishihara, S. J.: Neomycin Blood Levels in Man, Am. J. Clin. Path. **20**: 670, 1950.

Preliminary tests showed that little neomycin is excreted through the intestines or absorbed from them. Approximately 30 times larger doses have to be given by mouth to achieve a blood concentration comparable to that obtained by intramuscular injections. This paper,

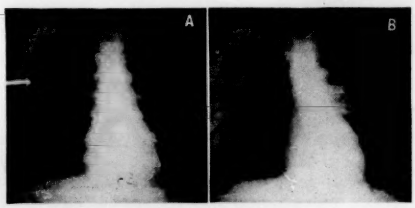

Fig. 1.—Primary atypical pneumonia. *A*, findings before treatment. *B*, clearing of the right lung after neomycin treatment.

however, does not contain reports on the oral application of neomycin.

Due to the relationship of neomycin to streptomycin and streptothricin, several unfavorable side effects had to be expected, such as kidney damage, disturbances of the auditory and vestibular apparatus, liver dysfunction and skin infections. In order to avoid them, urine specimens were examined about every second day; determinations of the nonprotein nitrogen in the blood were carried out weekly; urea clearance tests and hematological examinations were made at least once a month; the ears and the liver functions were checked as frequently as possible. The sedimentation rate of the red blood cells and the levels of neomycin were followed up weekly or semimonthly; if necessary, even more frequently.

The sedimentation rate of the red blood cells was measured by the Winthrop method, using proper correction tables. The neomycin blood levels were determined by the use of the serial tube dilution method, employing E. coli strain 9637, which has been used by Waksman and his associates [2a] for the determination of

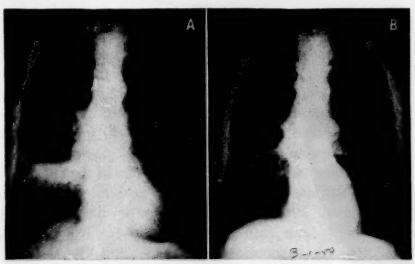

Fig. 2.—*A*, abscess of the right middle lung lobe and infiltration in the right lower lung lobe before treatment. *B*, same abscess after neomycin treatment.

neomycin potency. It was shown, however, that certain persons have inhibitory antibodies against this organism in their blood. These antibodies can be destroyed by heating the serum in a water bath for 30 minutes at 54 to 55 C. Parallel tests had to be run, therefore, with a Bacillus subtilis organism supplied by Dr. M. C. Bachman of the Commercial Solvents Corporation and with an Aerobacter aerogenes strain (isolated in our diagnostic laboratory and labeled SJH) that was sensitive to 0.8 to 1.2 units of neomycin.

The patients were selected from those admitted to Cook County Hospital. This, unfortunately, did not allow us to include in our study the treatment of early tuberculous lesions, in which antibiotic therapy is expected to produce favorable results. We felt, however, that due to the unknown side effects of the drug, only hospitalized patients should be treated at first.

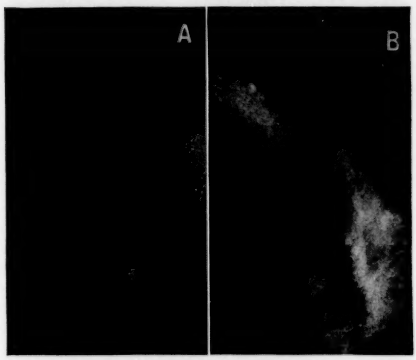

Fig. 3.—*A*, tuberculous abscess of the right axilla before treatment. *B*, same patient after neomycin treatment.

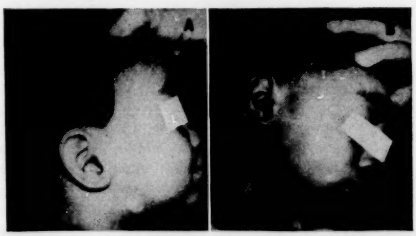

Fig. 4.—*A*, tuberculous submaxillary adenitis during neomycin treatment. *B*, same patient after neomycin treatment.

This paper represents a report on 31 patients treated with neomycin. The case histories were grouped according to the major causative organism. In order to keep the reports short, normal or unchanged results of renal, hematological, auditory and vestibular tests were not mentioned. Only pertinent neomycin blood levels and erythrocyte sedimentation rates were given. The course and the results of the treatment are given in five tabulations, grouping the cases according to the causative organisms. Two full histories, however, should be described.

Case 1.—D. W., an 8 month old boy, was admitted on Feb. 24, 1950 with convulsions. The patient was comatose; there was a spasticity of all extremities, a temperature of 103 F. and bulging of the tympanic membranes of both ears. He

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was given 2.5 grains (0.15 Gm.) of pentobarbital (nembutal®) rectally and 1 grain (60 mg.) of phenobarbital intramuscularly followed by intravenous calcium gluconate. These measures failed and chloroform was administered by inhalation. The lumbar puncture did not yield pertinent results. The patient was given 1 cc. of Bi-Pen® (a preparation containing procaine penicillin G and buffered crystalline penicillin G potassium), 1 Gm. of sulfadiazine immediately and 0.5 Gm. four times a day intravenously supplemented with 100,000 micrograms of streptomycin. Several hours later his temperature rose to 104.6 F. A bilateral myringotomy was performed. Serosanguineous material was obtained. The patient continued to have fever and convulsions involving mainly the left side of the body. There was dullness on the right side of the cranium on percussion. A bilateral papillar edema was present. Facial paralysis developed on the left side. Copious, purulent drainage from both ear canals revealed Pseudomonas aeruginosa, sensitive to 100 micrograms of streptomycin, 100 micrograms of aureomycin, 12.5 micrograms of chloramphenicol

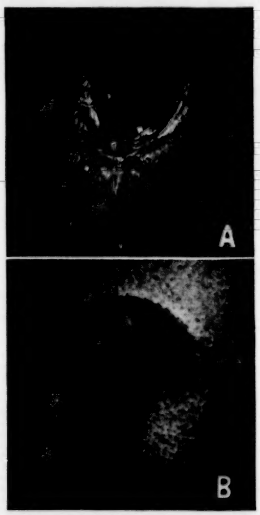

Fig. 5.—*A*, tuberculous ulcer of the sternum before neomycin treatment. *B*, same ulcer after treatment with neomycin.

and 1.56 units of neomycin per cubic centimeter of test fluid. Another lumbar puncture of the spinal cord did not yield pertinent results. The impression at this time was a right temporal brain abscess, secondary to a suppurative otitis media. On March 7, treatment of the patient was started with 100 mg. of aureomycin immediately and 200 mg. every four hours. The next day the patient continued to be comatose and had a temperature of 101 F. All medication was discontinued and neomycin, 450 units per kilogram of body weight, was given every four hours. The patient became afebrile the next day, and convulsions were not noted. The sedimentation rate was 21 mm. in one hour. The two hour neomycin blood level was 2.5 units. The ears stopped draining by March 11. Since March 21, the patient appeared to be normal. The sedimentation rate was 8 mm. in one hour. Neomycin was discontinued. The patient was discharged without residua on March 29.

Case 2.—C. L. B., a 27 year old man, became ill with night sweats, fever to 105 F. and pain in the right upper part of the chest during the third week of March 1950. On April 8, on admission, the temperature was 100.4 F. and the roentgenogram showed a localized area of pneumonitis in the right upper lung field, about 2.5 by 0.5 cm. in diameter, and enlargement of both hili. The cold agglutinin test was positive to a dilution of 1:32. Primary atypical pneumonia was diagnosed. The patient received 550 units of neomycin per kilogram every four hours. He became afebrile on April 10, when neomycin was discontinued. The roentgenogram of the chest showed a decrease of the size of the shadow to 1.5 by 0.5 cm. On

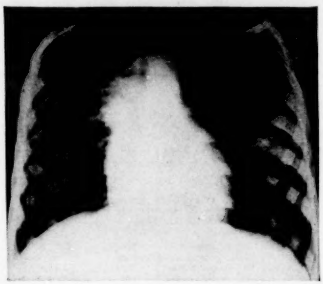

Fig. 6.—Area of consolidation in the right upper lung field of patient D. V.

April 19, the chest plate showed further decrease of the shadow and increased hilar markings (fig. 1). The patient was discharged.

The results of treatment in other patients is shown in the tables. Table 1 shows dramatic response in one patient and no result in two patients with brucellosis. Table 2 demonstrates good response in two patients with shigellosis and in three with salmonellosis. The favorable reaction in shigellosis, however, may be due to the natural course of this disease. The unusually high neomycin level in the blood of patient L. S. afflicted with Salmonella pneumonitis and a lung abscess (table 2) was probably due to diminished neomycin excretion because of the decompensated heart and subsequent circulatory stagnation. Patient H. W. of the same table was given streptomycin in order to increase the unsatisfactory low neomycin blood level.

Table 3 as well as case 1 shows the excellent action of neomycin on Escherichia, Aerobacter and Pseudomonas infections. Patient L. M. died of diabetes; patient M. B. harbored a Proteus morgani which was resistant to 100 units of neomycin as well as to more than

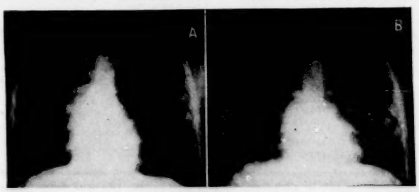

Fig. 7.—*A*, clearing of right lung of patient D. V. after 18 days of neomycin treatment. *B*, further improvement after 60 days of neomycin therapy.

100 micrograms of streptomycin, chloramphenicol and aureomycin (table 3). This was the first instance in which such an organism has been observed. Case 2 demonstrates the beneficial action of neomycin on so-called atypical virus pneumonia. It is, however, impossible to draw conclusion from only one observation.

Table 4 summarizes the results of the treatment of seven patients with extrapulmonary tuberculosis, of whom three did not benefit from previous streptomycin treatment. The results were uniformly good. No untoward effects of the treatment were observed in this group. Table 5 shows the failure of neomycin therapy in advanced lung tuberculosis and in tuberculous meningitis. Patient D. V. of the table improved considerably, but tubercle bacilli were still present in her sputum after completion of the neomycin course.

As to the toxic effects of neomycin, complete deafness developed in patient L. S. (table 2). Two others, patients W. C. and J. S. (table 4), had some loss of hearing in the higher frequencies, which improved after the discontinuation of the drug. No vestibular involvement was observed.[6]

TABLE 1.—*Results of Neomycin Treatment of Brucellosis*

Patient	Age, Yr.	Data on Admission	Polyvalent Agglutination for Brucella: Date	Polyvalent Agglutination for Brucella: Titer	Sedimentation Rate: Date	Sedimentation Rate: Mm. in 1 Hr.	Dosage of Neomycin: Date	Dosage of Neomycin: Units/Kg.	1 Hr. Neomycin Blood Level, Units/Cc.	Result
R. W.*	34	Fever and chills 1 week; daily rise in temperature to 104 F.	1/25/50 2/ 3/50 3/11/50 6/ 6/50	1:320 1:2,560 1:800 1:320	1/25/50 2/ 3/50	47 3	1/25/50 to 2/3/50	300 q. i. d.	1.25	Excellent response; afebrile and asymptomatic in 18 hours
J. A.*	35	Fever and chills 1 week; daily rise in temperature 104 to 105 F.; palpable spleen †	2/10/50	1:800	.....	..	2/17/50 to 2/27/50	570 q. 4 h.	20	No response; patient treated successfully with streptomycin and sulfadiazine
P. C.	19	Fever and chills 9 days; daily rise in temperature 103 to 104.2 F.	3/27/50	1:1,600	3/27/50 3/29/50 4/ 6/50	16 23 28	3/27/50 to 4/6/50 4/ 6/50 to 4/8/50	560 q. i. d. 1,000 q. i. d.	1.25 10	No response; patient treated successfully with streptomycin and sulfadiazine

* Stockyard worker.
† Brucella suis had been isolated from patient's blood on two previous admissions. He was treated with chloramphenicol.

TABLE 2.—*Response to Neomycin Therapy in Shigella and Salmonella Infections*

Patient	Age, Yr.	Data on Admission	Bacteriologic Data	Sedimentation Rate: Date	Sedimentation Rate: Mm. in 1 Hr.	Sensitivities *: S	A	C	N	Dosage of Neomycin: Date	Dosage of Neomycin: Units/Kg.	Neomycin Blood Level: Hr. After Administration	Neomycin Blood Level: Units/Cc.	Result
P. B.	4	Diarrhea with blood and mucus for 1 week; temperature 100.8 F.	Sh. paradysenteriae type 2 from stools	.....	..	..	1.6	0.09	0.8	2/16/50 to 2/20/50	500 q. i. d.	1	1.25	Diarrhea subsided 2/18/50; no Shigella found in stools on reexamination
J. E.	17	Bloody diarrhea and fever for 10 days; temperature 103 F.	Sh. paradysenteriae type 2 from stools	.....	..	..	1.6	0.09	1.6	2/16/50 to 2/24/50	400 q. i. d.	1	1.50	Diarrhea subsided 2/18/50; afebrile 2/19/50; no Shigella found in stools
L. S.	65	Decompensated arteriosclerotic heart disease, abscess right middle lung lobe (fig. 2); fever to 100 F.; night sweats; had been treated with penicillin and sulfadiazine	S. typhimurium repeatedly from sputum and stools	2/12/50 2/24/50 3/ 2/50	26 12.5 6	..	6.25	7.25	6.25	2/12/50 to 3/2/50	500 q. 4 h.	1 1 3	10.0 50.0 † 20.0	Fever and night sweats subsided by 2/24/50; neomycin discontinued 3/2/50 due to loss of hearing; no Salmonella found in stool or sputum on reexamination; x-ray showed considerable improvement; patient died 3/21/50 due to posterior wall infaret of heart
H. W.	4	Fever of 104 F.; bilateral bronchopneumonia	S. typhosa from blood (4/20/50); typhoid "O," 1:320; typhoid "H," 1:160	4/ 6/50 4/13/50 4/17/50 4/20/50	28 18 22 19	50	12.5	1.4	3.2	4/6/50 to 4/11/50 4/11/50 to 4/14/50 4/14/50 to 4/18/50	500 q. 4 h. 750 q. 4 h. 1,000 q. 4 h.	2 1 1	0.625 25 ‡ 50	Afebrile 4/17/50; no Salmonella found in blood, urine or stools; bronchopneumonia cleared
N. O.	4	High fever, abdominal pains and liquid green stools for 2 weeks; previous treatment with sulfadiazine and penicillin; temperature 102.8 F.	S. typhosa from stools (4/24/50); typhoid "O," 1:320; typhoid "H," 1:320	4/25/50	0	25	12.5	0.7	0.03	4/24/50 to 4/29/50	750 q. i. d.	1	12.5	Afebrile 4/25/50; nasopharyngitis developed 4/27/50, responded to penicillin; no Salmonella found in blood, urine or stools on reexamination

* Sensitivities to streptomycin (S), aureomycin (A) and chloramphenicol (C) are expressed in micrograms and neomycin (N) in micrograms per cubic centimeter of test fluid in tables 2 and 3.
† Patient's heart was decompensated.
‡ Combined blood level due to addition of 10 mg. streptomycin; one gram was administered from April 11 to April 14, 1950.

Patient W. C. (table 4) showed an elevation of the nonprotein nitrogen with normal urinary findings. Patient L. S. (table 3) had microscopic hematuria which disappeared after neomycin was stopped. Albuminuria appeared when the drug concentration in the blood of patients K. H. and E. W. (table 5) reached a

6. Since this paper has been submitted for publication, one more case of permanent deafness has been observed.

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one hour level of 40 units. Thus a one hour blood level of 40 units may be considered a sign of a toxic concentration of the drug. The injections were tolerated well, except for pain when the concentration of the drug exceeded 20,000 units per cubic centimeter of injected fluid.

per kilogram of body weight is given four times a day. Another group of patients with pulmonary tuberculosis is now under treatment. The results will be reported at a later date.

While one is inclined to be enthusiastic about new drugs with wide antibacterial spectrums and strong in

* TABLE 3.—*Neomycin Therapy in Escherichia, Aerobacter and Pseudomonas Infections*

Patient	Age, Yr.	Diagnosis	Sedimentation Rate: Date	Sedimentation Rate: Mm. in 1 Hr.	Urine	Culture	Previous Treatment
C. C.	39	Chronic cystitis with renal and bladder calculi	.....	..	Many RBC's and WBC's	E. coli from urine	Sodium acid phosphate, methanamine
H. F.	52	Myxedema, pyelitis	4/ 8/50 4/20/50	23 15	Loaded with WBC's	E. coli from urine	.....
G. K.	47	Postoperative abdominal wound	.....	..	.....	Ps. aeroginosa from wound	Streptomycin, penicillin
E. M.	5	Pyelitis	4/15/50 4/21/50	38 14	Moderate number of RBC's and WBC's	E. coli from urine	.....
S. M.	77	Diabetes, pneumonia, cystitis	3/ 9/50 3/16/50	21 16	Loaded with RBC's and WBC's	A. aerogenes	Streptomycin
A. G.	41	Pneumonia, pyelonephritis	3/21/50 3/28/50 4/13/50	25 16 13	Loaded with WBC's	A. aerogenes	Methanamine, sodium acid phosphate, penicillin, streptomycin
L. S.	34	Pyelonephritis, vesicle neck obstruction	3/18/50 3/27/50	28 14	Loaded with WBC's	A. aerogenes	Streptomycin, penicillin
M. B.	54	Chronic pyelonephritis, diabetic nephrosclerosis	.....	..	Many RBC's and WBC's	A. aerogenes	Penicillin, chloramphenicol
D. B.	56	Pyelitis, tuberculosis suspected	3/ 8/50 3/28/50	36 16	Many RBC's and WBC's	A. aerogenes	.....
C. W.	46	Carcinoma of cervix, hydronephrosis, postoperative pyelonephritis	4/20/50 4/26/50	24 32	Loaded with WBC's	A. aerogenes	Streptomycin, penicillin

Sensitivities * S	A	C	N	Dosage of Neomycin: Date	Dosage of Neomycin: Units/Kg. q. i. d.	Neomycin Blood Level: Hr. After Administration	Neomycin Blood Level: Units/Cc.	Result
50	1.6	6.4	12.5	1/5/50 to 1/19/50	200	1½	1.25	Few WBC's in urine on 1/7/50; none 1/19/50; stones successfully removed surgically
.....	.....	.....	.....	4/8/50 to 4/14/50	400	3	0.625	No WBC's in urine 4/14/50; asymptomatic
>100	>100	>100	12.5	1/26/50 to 2/3/50	300	1	15.0	Drainage diminished and fistula healing by 2/3/50
6.25	0.5	1.4	1.56	4/15/50 to 4/21/50	750	1 1	12.5 25.0	Afebrile 4/19/50; no WBC's in urine 4/19/50
>100	12.5	12.5	3.12	3/9/50 to 3/16/50	350	5	20.0	Urine contained many RBC's but no WBC's 3/13/50; patient died 3/16/50; autopsy not allowed
>100	100	5.8	25	3/18/50 to 3/28/50	475	1½ 1½	20.0 25.0†	Afebrile 3/21/50; urine clear 3/25/50
100	12.5	25	3.12	3/18/50 to 3/21/50 3/21/50 to 3/27/50	450 700	1½ 1½ 8	5.0 80.0† 2.5	Afebrile 3/21/50; urine contained many RBC's, no WBC's 3/27/50; surgical relief of obstructions on 4/5/50 with good results
>100	>100	>50	25	3/17/50 to 3/28/50	200	1 1½	5.0 25.0†	Few WBC's in urine 3/28/50, generally improved; urine culture revealed resistant strain of P. morgani; Patient discharged 4/6/50
>100	12.5	25	15	3/23/50 to 4/15/50	500	1	2.5	Urine clear 3/28/50; patient referred to medical clinic for tuberculosis examination
100	50	23	0.78	4/19/50 to 4/26/50	425	1	5.0	Afebrile and only rare WBC's found in urine 4/23/50; patient referred to gynecologist for further treatment

* See footnote * to table 2.
† Urine neomycin levels.

While these cases may be the results of random-sampling, the overall picture seems favorable for neomycin, especially in infections caused by Salmonella, Pseudomonas, Escherichia, Aerobacter, Klebsiella, Proteus, and extrapulmonary tuberculosis, when 500 units

vitro action, the observed toxic effects of neomycin and failure in far developed tuberculosis caution against indiscriminate use, especially without proper assay of the neomycin blood levels. One also has to keep in mind the danger of deafness.

TABLE 4.—*Neomycin Therapy in Extrapulmonary Tuberculosis*

Patient	Age, Yr.	Clinical Summary	Previous Streptomycin Treatment	Sedimentation Rate: Date	Sedimentation Rate: Mm. in 1 Hr.	Dosage of Neomycin: Date	Dosage of Neomycin: Units/Kg.	Neomycin Blood Level: Hr. After Administration	Neomycin Blood Level: Units/Cc.	Result
W. C.	52	Tuberculous osteoarthritis of left knee with sinuses draining through 4 fistulas	1 Gm. daily for 3 mo.; no response	12/14/49 1/16/50 2/10/50	30 17 23	12/14/49 to 1/20/50	600 q. i. d.	3½	2.5	Sinuses healing and 3 fistulas closed by 1/16/50; sinuses closed 2/10/50
J. S.	19	Tuberculosis of right kidney; biopsy of bladder showed tuberculosis	2 Gm. daily for 3 mo.; no response	1/18/50 2/17/50 3/10/50 4/ 6/50	36 18 6 2	1/11/50 to 1/18/50 1/18/50 to 3/10/50	275 q. i. d. 350 q. i. d.	1 1½	5.0 10	Frequency, urgency, dysuria subsided by 2/20/50; urine free of cellular elements 3/10/50; cystoscopy showed marked improvement
A. S.	25	Tuberculosis of right axillary glands proven by biopsy; tuberculous abscess developed after 2 months of streptomycin (fig. 3)	1 Gm. daily for 2 mo.	1/ 5/50 1/20/50 2/10/50 3/ 9/50 4/ 6/50	39 19 13 12 3	1/5/50 to 1/12/50 1/12/50 to 1/18/50 1/18/50 to 3/14/50	350 t. i. d. 400 t. i. d. 260 q. i. d.	6 6 3½ 3	2.5 2.5 2.5 1.25	Abscess filled with necrotic tissue 2/10/50, no drainage; curettement of necrotic material on 2/20/50 followed by almost complete healing 4/6/50; other glands markedly diminished
L. T.	22	Tuberculous right anterior cervical lymph glands proven by biopsy	1 Gm. daily for 10 days	1/29/50 2/10/50 4/ 6/50	34 8 2	1/29/50 to 2/6/50 2/6/50 to 3/10/50	250 q. i. d. 450 q. i. d.	1 3	1.25 0.625	Lymph nodes diminished to almost ½ size, very hard and irregular on 3/10/50; patient gained 4 lb. and was discharged to clinic for follow-up care
G. F.	2	Tuberculous abscess of right submaxillary area (fig. 4)		1/20/50 1/28/50 2/ 9/50 4/11/50	28 17 5 8	1/20/50	500 q. i. d.	3	1.25	Abscess stopped draining by 3/13/50 and area surrounding site of drainage hard and indurated; granulation tissue and 2 lymph nodes excised on 4/4/50; wound completely healed on 4/11/50
F. B.	3½	Tuberculous sinus of right axilla and right epitrochlear area; sputum contained tubercle bacilli; biopsy of sinuses proved tuberculosis	1.2 Gm. daily for 22 days	1/ 6/50 1/12/50 2/17/50	13 20 6	1/6/50 to 1/18/50 1/18/50 to 3/12/50	550 t. i. d. 425 q. i. d.	3 1	1.25 2.50	Sinuses completely closed by 2/17/50
V. P.	25	Tuberculosis of sternum proven by biopsy (fig. 5)		2/17/50 3/21/50 4/20/50	22 21 * 6	2/17/50 to 3/21/50	500 q. i. d.	6	1.25	Lesion healing remarkably by 3/21/50; patient aborted at 8 weeks; lesion almost completely healed by 4/20/50

* This patient was pregnant.

TABLE 5.—*Failure of Neomycin Therapy in Advanced Lung Tuberculosis and in Tuberculosis Meningitis*

Patient	Age, Yr.	Clinical Summary	Previous Treatment	Sedimentation Rate: Date	Sedimentation Rate: Mm. in 1 Hr.	Dosage of Neomycin: Date	Dosage of Neomycin: Units/Kg.	Neomycin Blood Level: Hr. After Administration	Neomycin Blood Level: Units/Cc.	Results
D. V.	7	2 previous admissions for pulmonary tuberculosis in 1946, and in March 1949; patient readmitted on 12/3/49 with positive sputum and x-ray showing pneumonitis of right upper lobe (fig. 6)	Streptomycin 1.2 Gm. daily 3/9/49 to 5/9/49	1/ 2/50 1/27/50 2/ 7/50	26 4 10	1/19/50 to 4/19/50	425 q. i. d.	5 1	0.625 1.25	Fever subsided 1/24/50; considerable clearing 2/7/50 (fig. 7); further clearing 3/20/50; sputum still contained tubercle bacilli; patient sent to a tuberculosis sanitarium for pneumothorax 7/2/50 after development of a cavity found on 5/4/50
K. H.	13	Acutely ill with positive sputum for tubercle bacilli; x-ray evidence of abscess cavity and caseation in right upper lobe with bronchiogenic spread throughout both lung fields	None	1/12/50 2/10/50 3/25/50	24 8 32	1/6/50 to 1/12/50 1/12/50 to 1/18/50 1/18/50 to 4/11/50	312 t. i. d. 1,250 t. i. d. 623 q. i. d.	1½ 3	5.0 5.0	Afebrile 1/12/50; received penicillin and aureomycin from 1/25/50 to 2/6/50 for nasopharyngitis; chickenpox developed 2/28/50; x-ray of chest showed improvement on 4/6/50; tuberculosis meningitis developed on 4/7/50; patient died on 4/11/50; autopsy showed marked fibrotic reaction in lungs; bronchogenic spread throughout both lung fields and tuberculous meningitis
E. W.	2	Tubercle bacilli found in sputum; x-ray showed area of consolidation in right paratracheal area and right hilum of lung	Streptomycin 0.8 Gm. daily 12/25/49 to 1/5/50	1/ 5/50 2/ 3/50 3/24/50	25 30 18	1/5/50 to 3/24/50 3/24/50 to 4/8/50 4/8/50 to 4/17/50	400 q. i. d. 570 q. i. d. 1,400 q. i. d.	½ 1 1	2.5 1.25 40.0	Afebrile 1/8/50; chickenpox developed 3/9/50; and tuberculous meningitis on 3/24/50; patient died 4/17/50; autopsy showed miliary tuberculosis with tuberculous meningitis
B. J.	7	Tuberculous meningitis confirmed by spinal fluid findings and presence of tubercle bacilli in spinal fluid	None	4/ 6/50 4/14/50	4 27	4/3/50 to 4/16/50 4/6/50 to 4/14/50	500 q. i. d. 1,000 q. 4 h.	1 2 1 1	2.5 2.5* 12.5 6.25*	Patient showed no response; neomycin discontinued on 4/14/50 and streptomycin 1.2 Gm. daily was substituted; patient expired on 4/15/50; autopsy showed miliary tubercles throughout lungs, liver and meninges

* Spinal fluid level of neomycin.

SUMMARY

Thirty-one patients with so-called virus pneumonia and tuberculosis and diseases caused by gram-negative bacilli were treated with neomycin. The results were encouraging with the exception of far advanced cases of lung tuberculosis and brucellosis. The toxic effects were discussed.

629 South Wood Street.

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RETROPUBIC PROSTATECTOMY

ANALYSIS OF ONE HUNDRED CASES

John R. Hand, M.D.
and
Arthur W. Sullivan, M.D., Portland, Ore.

From June 18, 1948 to June 1950 we did 140 retropubic prostatectomies on private patients. There were no hospital deaths in this series. We are, however, reporting on only the first 100 consecutive operations so that there will be a follow-up observation of at least five months for the last patient.

During the period in which the 100 retropubic operations were carried out, we also did 42 transurethral resections (nine had carcinoma), two suprapubic prostatectomies (one had carcinoma) and 23 perineal prostatectomies (six had carcinoma). In this series there was one hospital death. It occurred after transurethral resection and was due to second degree burns sustained when the patient, a man of 80, inadvertently turned on the hot water faucet while his nurse left him to finish his sitz bath.

ANALYSIS OF 100 CASES

Age.—There were three patients in the fifth decade, 42, 48 and 49 years of age. The 42 year old man had prostatic stones and gave a history of rupture of the urethra following injury; the 48 year old man had benign prostatic hyperplasia, and the 49 year old man had carcinoma of the prostate. The oldest patient was 79; the average age for the 100 patients was 65. Fifty-six patients were between 60 and 69, and nine of these had carcinoma.

Symptoms.—On admission the symptoms were as follows: acute retention, 26 cases; difficulty in voiding, 92; frequency, 64; hematuria, one; chills and fever, six; urethral stricture requiring repeated dilatation, five; incontinence, one. Sixteen patients gave histories of previous transurethral resections.

Cardiovascular Examination.—Twenty-three patients had systolic blood pressure readings of 170 or over, the highest being 230. Ten patients had symptoms and signs of myocardial damage.

Rectal Examination.—Graded on a basis of 1 to 4, 25 patients had small prostate glands (1 to 1 +), 54 had medium glands (2 to 2 +) and 21 had large glands (3 to 3 +). The findings in 74 patients pointed to benign prostatic hyperplasia. Five patients had such evidence of advanced carcinoma as hardness, fixation and infiltration of the seminal vesicles. Twenty-one had minimal suggestive signs of malignant change, that is, asymmetry and unilateral firmness. None of the patients had a palpable nodule.

Laboratory Studies.—Only one patient had a significant elevation of the blood urea nitrogen. His urea was 116 mg. per 100 cc., and he had acute retention with 1,600 cc. of residual urine. After three days of catheter drainage the urea value was reduced to 31 mg. An additional 43 patients had residual urine varying from 30 to 260 cc.

Red blood cells were found in the urine of 62 patients, and white blood cells were present in the urine of 80. The range of each type of cell was from occasional to 50 per high power field.

Operative and Pathological Observations.—Hyperplasia in some degree was present in the glands of all the patients. In some instances a large gland noted on rectal examination proved at operation to be a small amount of hyperplastic tissue and a considerable amount of compressed prostatic tissue with a thickened capsule. It is important to recognize compressed tissue and to remove it in order to obviate the possibility of recurrence.

Besides hyperplasia, 39 patients had one or more of such associated diseases as prostatitis, presence of calculi, fibrosis, infection or abscess (table 2 [1]). Among these were 13 of the 21 patients who had presented minimal suggestive signs of carcinoma on rectal examination. The clinical findings of these 13 patients were attributed to the associated disease. However, the other eight patients with minimal suggestive clinical findings proved to have relatively early carcinoma when the fixed sections were studied. Two had small and six had medium prostate glands.

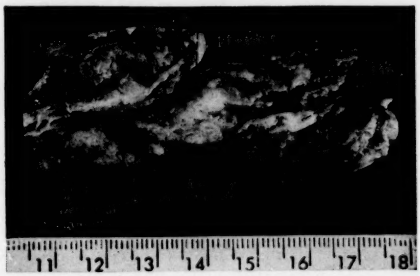

Fig. 1.—Autopsy specimen showing position of posterior lamella below ejaculatory ducts. At the apex of the posterior lamella is a dense fascia. Just beneath the trigone are the fibromuscular attachments of the bladder.

In each of the eight cases of early carcinoma it had been necessary to remove the posterior lamella to get all the suspicious tissue (fig. 1). In four instances the posterior lamella peeled out easily; in the other four it had to be dissected out in pieces. Microscopic study showed some degree of invasiveness in all eight glands. In three the invasion was confined to the posterior lamella; in five it had extended to the lateral lobes. It is of significance that four of the five glands with extension to the lateral lobes had been difficult to dissect. In all eight cases the seminal vesicle areas appeared to be normal on bimanual examination at the time of the operation. In all eight cases we believed all the suspicious tissue had been removed.

In table 3 are summarized the clinical findings, treatment, type of malignant growth and postoperative sexual potency [1] of the eight patients with early and the five patients with late carcinoma. It will be noted

Read before the Section on Urology at the Ninety-Ninth Annual Session of the American Medical Association, San Francisco, June 29, 1950.

1. Because of lack of space, tables 1, 2, 4, 5 and 6 and the last two columns (headed Additional Therapy and Sexual Potency Before and After Prostatectomy) of table 3 are omitted from THE JOURNAL; they will appear in the authors' reprints.

that the eight early neoplasms were all of the acinar type, the degree of malignant change varying from grades 1 to 3. Of the five advanced lesions, four were of the multiacinar type of either grade 3 or grade 4 and the fifth was a grade 2 clear cell type. In a previous study it was observed that the incidence of metastases and deaths due to cancer was higher among patients with multiacinar lesions than among those who had either the acinar or the clear cell variety.[2] It was also observed that patients with multiacinar neoplasm did not respond as well to orchiectomy as those with either of the other two types of cancer.

Of further interest is the fact that four of the 13 patients with carcinoma (two with early and two with advanced lesions) had had previous transurethral resections. One patient (case 1, table 3) had had no signs of carcinoma on rectal examination prior to his resection. Thirteen years later, when the retropubic prostatectomy was done and the diagnosis of carcinoma was established, the only palpable change in the prostate on rectal examination was firmness.

The second patient (case 2) had had no clinical signs suggestive of malignant growth in 1938, when his resection was done. Just before the retropubic prostatectomy, 11 years later, the clinical findings were suggestive of carcinoma.

The third patient (case 12) was thought to have carcinoma of the prostate when he was first seen in 1946 because his gland was asymmetrical and the seminal vesicle areas were infiltrated. The pathological diagnosis on tissue removed transurethrally was benign hyperplasia. In 1948 extension of the process was noted on rectal examination, and at the time of the retropubic prostatectomy malignant invasion of the bladder base and seminal vesicles was found.

The fourth patient (case 13) had an asymmetrical, firm prostate in 1944. In 1948 there was seminal vesicle infiltration, in addition to asymmetry and unilateral firmness of the gland. When the retropubic prostatectomy was done, it was observed that the bladder mucosa distal to the ureteral orifices, as well as the seminal vesicles, was involved in the carcinoma.

Postoperative Course.—Antibiotics were given to 81 patients (penicillin, 53; penicillin and combisul* [a mixture of sulfadiazine, sulfathiazole and sulfamerazine], 28). Three patients had skin rashes that developed on the seventh, eighth and eleventh postoperative day, respectively. In each instance the reaction lasted a week.

Two patients had no elevation in temperature at any time during their hospitalization; two others had low grade fever throughout their hospital stay. The fever range of the 98 patients was 99 to 104.4 F., with an average febrile course of 3½ days. Twenty patients had a second temperature rise. The associated or contributing factors were removal of drains, four patients; removal of catheter, three; pneumonia, one; bleeding, one; epididymitis, two, and wound infection, five; no apparent cause was found in four patients.

Significant bleeding occurred in seven instances. Two patients bled twice. One bled from the prostatic bed during the first 24 hours after operation and into the space of Retzius on the ninth postoperative day. The other bled on the twelfth postoperative day and again on the sixteenth. Cystoscopy was done each time with a view to fulgurating the bleeding area. On each occasion the clots were removed, but no active bleeding was encountered. Since our experience with the patient who bled on the train when he returned to his home on the thirteenth postoperative day, we have insisted that no patient leave the city for at least 18 days after the operation.

While 12 patients had bladder spasm, the incidence of this condition is considerably lower than it was when we used a Pilcher bag after suprapubic prostatectomy. We, as well as others, have been impressed with the comfortable convalescence that the majority of the patients experience after the retropubic operation.

The patient on whom we did our first retropubic prostatectomy had thrombophlebitis in the left leg on the third postoperative day. As we had packed the

TABLE 3.—*Summary of Findings and Treatment in Thirteen Cases of Prostatic Carcinoma*

Case No.	Age	Prior TUPR*	Prostate on Rectal Examination		Tissue Removed	Lesion Type† and Grade
			Size	Character		
1	65	Yes	2	Smooth, symmetrical, firm	Prostate, posterior lamella (invasion to lateral lobes)	A-2
2	57	Yes	2	Asymmetrical, firm	Prostate, posterior lamella (invasion to lateral lobes)	A-2
3	61	No	2	Firm, asymmetrical	Prostate, posterior lamella (invasion within posterior lamella)	A-2
4	66	No	2	Firm	Prostate, posterior lamella (invasion to lateral lobes)	A-3
5	49	No	1	Asymmetrical, firm	Prostate, posterior lamella (invasion within posterior lamella)	A-1
6	62	No	2	Asymmetrical	Prostate, posterior lamella (invasion within posterior lamella)	A-1
7	64	No	2	Firm	Prostate, posterior lamella (invasion to lateral lobes)	A-1
8	63	No	1	Asymmetrical, firm	Prostate, posterior lamella (invasion to lateral lobes)	A-1
9	72	No	2	Hard, fixed, seminal vesicle extension	Prostate, posterior lamella, seminal vesicles (extensive carcinoma)	M-4
10	61	No	3	Stone hard, fixed, seminal vesicle area infiltrated	Prostate, capsule, posterior lamella, seminal vesicles (extensive carcinoma)	CC-2
11	60	No	3	Smooth, firm, fixed	Prostate, posterior lamella, seminal vesicles, part of trigone (extensive carcinoma)	M-4
12	71	Yes	1	Hard, nodular, fixed, seminal vesicle extension	Obstructing prostatic tissue, part of trigone (extensive carcinoma)	M-3
13	67	Yes	1	Firm, seminal vesicles infiltrated	Obstructing prostatic tissue, part of trigone (extensive carcinoma)	M-4

* Transurethral prostatic resection.
† A indicates acinar; M, multiacinar, and CC, clear cell.

2. Hand, J. R.: A Study of Various Treatments for Carcinoma of the Prostate: Analysis of 109 Cases, J. Urol. 64: 123-148 (July) 1950.

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fossa on either side of the prostate, we wondered whether the packing had been a factor in causing this complication. We have not used packing since, and there was no other instance of thrombophlebitis in this series. However, in one of the 40 patients who were later operated on phlebothrombosis developed even though we had not used packing. This man had a history of a previous episode of this complication. Now if we have a patient with a similar history or if the bleeding and clotting times are rapid, we consider postoperative management with bishydroxycoumarin (dicumarol*).[2a]

One patient had drainage of urine from the wound four days after operation. He had a carcinoma. Wishing to widen the vesical orifice, we closed the vertical incision we had made through the capsule and first centimeter of the bladder horizontally. We have not repeated this type of closure.

Twenty-three patients had serous drainage. We believe inflammation in the space of Retzius accounted for this complication.

Other early postoperative complications were hiccup intermittently for seven days, one patient; ileus, one; bronchopneumonia, five; epididymitis, two; gout of the big toe (fourth postoperative day), one; wound infection, 11; fibrositis (rectus sheath), three.

In view of the current interest in osteitis pubis, it is of interest that three patients in their early postoperative convalescence had exquisite tenderness and spasm of one rectus muscle. We attributed this to fascitis. In each instance the condition cleared after local application of heat. Roentgenograms made at the time the patients were in the hospital and subsequently have shown no evidence of osteitis pubis.

Osteitis pubis was first described as a clinical entity by Beer in 1924 and 1928.[3] In a comprehensive review of the literature in 1945, Muschat [4] was able to find only 25 cases, including two of his own. In each of the 25 cases the osteitis pubis had followed an operation other than retropubic prostatectomy. As the number of papers on the retropubic operation has increased,[5] more and more cases of osteitis pubis following this procedure have been reported. The incidence of osteitis pubis following retropubic prostatectomy now varies from 0 to 17 per cent.

In view of the aforementioned reports, we believe it is extremely important not to disturb the transversalis fascia in the space of Retzius. We separate this fascia in the midline with caution and are particularly careful not to strip it from its attachment at the pubis or to traumatize it in any way with sponges, needles, retractors or the hands.

Removal of Drains, Catheters and Sutures.—The Penrose drains in the space of Retzius (two drains) were in most instances removed on the sixth day. In 12 instances, however, they came out with the dressing on the first postoperative day. To make sure they do not come out too early, we place a suture through the drains, in addition to using safety pins.

The catheters were removed on the seventh, eighth, ninth, tenth, eleventh or twelfth postoperative day. In most cases, however, they were removed on the ninth day.

The sutures in the majority of cases were removed on the tenth day.

Hospitalization.—The number of days the patients spent in the hospital ranged from seven (two patients) to 27 (one patient with delayed bleeding). The average number of hospital days was 13.5.

Late Complications.—After discharge from the hospital, a number of patients had to be treated for various complications. Seven required dilation for stricture of the meatus. The incidence of this complication can be lessened by doing a meatotomy when the catheter is inserted if the meatus is tight, by shortening the period of catheter drainage or, as we now do, by using a smaller catheter (a no. 22 instead of a no. 24 Foley catheter). Nine patients had tight vesical necks. Eight responded to urethral dilatation, and one required transurethral resection of the posterior lip of the vesical mucosa. One patient exhibited multiple urethral strictures which responded to dilatation. Three patients had epididymitis 1½, two and four months postoperatively. One patient had an episode of acute pyelonephritis seven months after his operation and was hospitalized for a week.

Of the 29 patients who were given transfusions, one had homologous serum jaundice. He was 60 years old. On the day of the operation, March 28, 1949, he had been given a transfusion of 500 cc. of whole blood, and on the thirteenth postoperative day he was discharged in good condition after an uneventful convalescence. The jaundice appeared on June 22, 86 days after the transfusion. Visible jaundice continued until July 28. During the interval of the jaundice he was on a high carbohydrate, high protein, low fat diet, and he received sodium dehydrocholate (decholin* sodium) and thiamine hydrochloride. On Sept. 6, 1949, he was asymptomatic and the icterus index was 6.

Homologous serum jaundice occurs within two to four months in 4 to 5 per cent of patients who receive pooled plasma.[6] The incidence after transfusion of whole blood is lower. Homologous serum jaundice is caused by a filtrable virus that is transmitted by parenteral injection of blood or its products or by contaminated needles and syringes. As small an amount as 0.01 cc. of contaminated serum may produce the condition.[7] The virus of homologous jaundice is different from that of infectious hepatitis. Evidence of this is the

2a. To minimize the possibility of such complications, we have, since this paper was written, been attempting to maintain high levels of antithrombin routinely with epsilan phosphate (alpha tocopherol phosphate). It is given intragluteally and orally in combination with calcium gluconate administered intravenously, as suggested by Kay and associates (Kay, J. H.; Balla, G.; Hutton, S. B., and Ochsner, A.: The Prophylaxis of Intravascular Clotting by the Use of Alpha Tocopherol and Calcium, New Orleans M. & S. J. **103**: 116-120 [Sept.] 1950).

3. Beer, E.: Periostitis and Ostitis of the Symphysis and Rami of the Pubis Following Suprapubic Cystotomies, J. Urol. **20**: 233-236 (Aug.) 1928.

4. Muschat, M.: Osteitis Pubis Following Prostatectomy, J. Urol. **54**: 447-458 (Nov.) 1945.

5. Moore, T. D., in discussion on Lavalle, L. L., and Hamm, F. C.: Osteitis Pubis: Its Diagnosis and Treatment, J. Urol. **61**: 83-95 (Jan.) 1949. Abrams, M.; Sedlezky, I., and Stearns, D. B.: Osteitis Pubis, New England J. Med. **240**: 637-641 (April 21) 1949. Farman, F., and Lemon, K. A.: Retropubic Prostatectomy Log, Urol. & Cutan. Rev. **53**: 584-589 (Oct.) 1949.

6. Snell, A. M.: Fundamentals in the Diagnosis of Jaundice, J. A. M. A. **138**: 274-279 (Sept. 25) 1948.

7. Butt, H. R., and Baggenstoss, A. H.: Problems Encountered in the Diagnosis of Serum and Infectious Hepatitis, S. Clin. North America **27**: 926-944 (Aug.) 1947.

fact that the incubation period of infectious hepatitis is 15 to 40 days and that the virus can be found in the stool, whereas the incubation period of homologous serum jaundice is 60 to 150 days and the virus cannot be recovered in the stool.[8]

Follow-Up Studies.—The postoperative results were checked to June 1, 1950 by means of a questionnaire or an office visit. One patient died nine months after his prostatectomy from carcinoma of the stomach.

At the time of the follow-up there was no instance of incontinence. However, one patient with carcinoma of the prostate had difficulty getting control for four months postoperatively. During this period he was encouraged to practice starting and stopping the stream. Seven patients complained of frequency. Two reported difficulty in starting to void. All the men said the caliber of the stream was satisfactory.

To determine what effect retropubic prostatectomy had on sexual potency, we asked the patients to answer a questionnaire we had prepared. One set of questions was directed to the preoperative status of desire, erections, ejaculations and sensation accompanying ejaculations. Another set was directed to the status of these factors after the retropubic operation.

It was exceedingly difficult to evaluate the replies. So as not to overlook the changes incident to age, we arranged the data according to age in decades. Of the 84 men who answered the questions, 34 (30 older than 60 years) said their sexual potency had been low prior to operation. Seven of the 34 had been castrated (diethylstilbestrol treatment, five; orchiectomy and diethylstilbestrol treatment, two).

Of 50 patients (30 older than 60 years) who had had good sexual function prior to operation, 25 experienced diminution in potency after the operation. One of these had had diethylstilbestrol, and another had had orchiectomy and diethylstilbestrol. We had also asked the patients to estimate the percentage of diminution they had noted. Five men, 63 to 68 years old, reported complete loss of function; three aged 65 to 77, had 75 per cent loss; three, 60 to 65 years of age, had 50 per cent loss; four (42, 59, 60 and 74 years old) had 25 per cent loss; one, aged 51, had 15 per cent loss; seven aged 57 to 75, had 10 per cent loss, and two men, aged 63 and 65, had 5 per cent loss. Three patients who had had as much as 75 per cent loss immediately after operation said they noticed continued subsequent improvement. One man who had good function immediately after operation reported the potency was now diminishing. Only one patient had complained to us about his loss of potency before we sent the questionnaire, and he wanted some treatment. He was not married and 63 years old. The others apparently accepted their diminished potency philosophically, and some attributed it to their advancing age.

Twenty of the 84 patients reported improvement following the retropubic operation. Eleven had previously had good function, and nine had had diminished function. Their estimates of the improvement varied from 10 to 94 per cent.

VARIATIONS IN RETROPUBIC TECHNICS

One of us (J. R. H.) recalls having heard Dr. L. C. Jacobs, of San Francisco, present a report in 1933 on "prevesical prostatectomy," which he and his associate, Dr. E. J. Casper, had carried out on three patients. Jacobs and Casper[9] stressed preservation of the continuity of the urethra, as well as of the ejaculatory ducts and seminal vesicles. They did not believe incision in the bladder or drainage of the surgical wound were necessary.

About the same time, Hybbinette[10] reported his results with an operation developed by Hendriksson, of Sweden. In this operation the prostate and capsule were incised in the midline over a catheter, then the incision was extended through the bladder neck. The adenoma was enucleated bimanually from just above the verumontanum to the bladder neck, and the vesical mucosa was apparently not incised as in our procedure. Drainage of the bladder was provided by means of a de Pezzer catheter brought out through the bladder and urethra in a retrograde manner with the help of the catheter previously inserted through the urethra into the bladder. Most of the bulbous end of the de Pezzer catheter was cut off, and the funnel-like end that remained was brought to rest against the bladder neck. Eight to 12 days later the de Pezzer catheter was replaced with a no. 20 or 22 French catheter. Part of a suprapubic tamponade, which was also used, was allowed to remain for five to seven days.

Millin,[11] of England, who reported his retropubic technic in 1945, advocated a horizontal incision in the prostatic capsule. Like Jacobs and Casper, he did not believe it was necessary to incise the bladder. He removed a wedge of mucosa on the posterior surface of the vesical neck.

Bacon,[12] in the United States, stressed close adherence to the principles laid down by Millin.

Ward,[13] also of England, used a vesicocapsular incision that he started in the bladder and extended distally. The bladder incision was large enough to insert a self-retaining retractor. Our bladder incision is 1 cm. long, and we use an army retractor. Ward tried to avoid cutting the prevesical fascia containing the blood vessels, and he increased exposure by elevating the fascia with a ¾ inch (1.9 cm.) retractor blade. We incise this fascia to get additional exposure. Ward incised the freed anterior commissure with scissors, one blade of which was placed in the urethra. We do not. In one third of his cases (16) Ward used a suprapubic tube. We plan to enucleate the gland in one piece and have not found it necessary to use a suprapubic tube, except in our one case of total prostatectomy for carcinoma.

8. Schiltz, F. H.: Epidemic (Infectious) Jaundice and Homologous Serum Jaundice, M. Woman's J. **55**: 17-32 (Jan.) 1948.
9. Jacobs, L. C., and Casper, E. J.: Pre-Vesical Prostatectomy, Urol. & Cutan. Rev. **37**: 729-732 (Oct.) 1933.
10. Hybbinette, S.: Suprapubische transurethrale Prostatektomie, Arch. klin. Chir. **183**: 145-147, 1935.
11. Millin, T.: Retropubic Prostatectomy: A New Extravesical Technique; Report on 20 Cases, Lancet **2**: 693-696 (Dec. 1) 1945; Retropubic Prostatectomy: Experiences Based on 757 Cases, ibid. **1**: 381-385 (March 5) 1949.
12. Bacon, S. K.: Retropubic Prostatectomy: Early Technical Difficulties; Report of Removal of Giant Prostate, J. Urol. **61**: 571-574 (March) 1949.
13. Ward, R. O.: Vesicocapsular Prostatectomy, Lancet **1**: 472-474 (March 27) 1948.

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In our first retropubic prostatectomy on June 18, 1948, we made a transverse incision in the skin. Then we tried a low midline skin incision. For the next few months we alternated between the two incisions (table 6 [1]). Finally, we concluded that the low midline incision was the better because it preserves the transversalis fascia and affords ready access to the prevesical space and the prostatic capsule.

In the prostatic capsule we tried first a transverse then a vertical incision (table 6 [1]). On Oct. 13, 1948 we encountered a carcinoma that had invaded the trigone. Because it was necessary to visualize the ureteral orifices, we extended the vertical capsular incision 1 cm. into the bladder. Since then, we have used this combined prostate and bladder incision with increasing frequency and carried it out in 30 of the 100 cases (table 6 [1]). We have also used it in the 40 retropubic prostatectomies not included in the study.

PROSTATICOVESICAL INCISION TECHNIC AND MANAGEMENT OF PATIENTS

Preoperative Care.—If acute retention has been present, the bladder is decompressed gradually by catheter drainage. Slow decompression allows overstretched vessels, nerves and muscles to regain better physiological function. The rate of decompression should be adjusted to the duration of the retention. We often use a no. 4 ureteral catheter when the retention is of long duration. When it is of shorter duration, we institute more rapid drainage through a urethral catheter. If the urea level is elevated and cannot be reduced by catheter drainage, we do a cystostomy. When this is necessary, we do not carry out the retropubic operation later. Patients with urinary infection are given appropriate antibiotics. To aid in wound healing, we prescribe vitamin C in the form of lemon and orange juice to be taken for a week before operation, when possible. When we wish to insure a positive protein balance, we administer testosterone propionate, provided there is no carcinoma present.

Anesthesia.—The night prior to operation the patient is given 1½ grains (0.1 Gm.) of pentobarbital (nembutal®). The next morning he is given 1½ grains of pentobarbital, ⅙ grain (10 mg.) of morphine and $\frac{1}{150}$ grain (0.4 mg.) of atropine or scopolamine hydrobromide.

We prefer low spinal anesthesia. Our usual technic includes administration of 50 mg. of ephedrine in the 1 per cent procaine (novocain®) hydrochloride solution used to anesthetize the skin preliminary to introduction of the spinal needle. The solution injected into the spinal canal consists of 50 mg. of procaine and 10 mg. of tetracaine (pontocaine®) hydrochloride in 3 cc. of spinal fluid.

Of the 100 patients 10 who had objected to spinal anesthesia were given thiopental (pentothal®) sodium intravenously in doses varying from 0.7 to 1 Gm. This was supplemented with oxygen inhalation and administration of curare. The dose of curare varied from 4 to 10 cc. (3 mg. in a 10 cc. vial). It was interesting to learn that the blood pressure drop during the first two hours after operation was considerably greater after the administration of curare than after the induction of spinal anesthesia (fig. 2).

Skin Incision.—The low midline incision is started at the level of the symphysis and is extended 10 to 12 cm. proximally. After the incision has been carried through the fascia and the rectus and pyramidalis muscles have been separated, the fascia along the medial border of each rectus muscle is divided. This exposes the muscles and allows the transversalis fascia to be depressed downward. At the lower end of the incision the transversalis fascia is penetrated in the midline. This gives access to the space of Retzius. Care is taken not to disturb the transversalis fascia at its attachment to the symphysis or its reflection over the prostate and bladder. A Balfour retractor is inserted, and the wound is spread apart. The fascia in the midline is then further incised, the incision being made as close to the symphysis as possible. This usually gives an additional centimeter of length and better exposure of the prostate. An anterior retractor is not used during the operation.

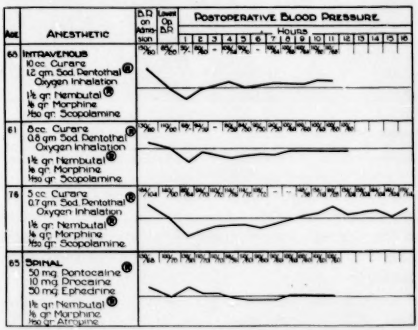

Fig. 2.—Chart showing blood pressure curves following intravenous administration of anesthetics and spinal anesthesia. Note drop in postoperative blood pressure in three of the patients who were given curare.

The patient is now placed in the Trendelenburg position, which allows the abdominal viscera to fall away from the bladder. Care is then taken to see that the shoulder rests are well padded and carefully placed over the scapulas. To prevent pressure on the brachial plexus, the rests must support the pectoral girdle. Pressure on the brachial plexus causes considerable postoperative distress and may be a factor in paralysis.

The peritoneum and bladder are depressed down and back to expose the prostatic capsule. Small veins coursing in the loose areolar tissue above the prostatic capsule are ligated.

Prostaticovesical Incision.—A vertical incision is started midway in the prostatic capsule and is extended through the first centimeter of the bladder. It is carried through the fascia, the true and false capsules of the prostate and the bladder wall (fig. 3). The incised bladder wall is spread apart with an army retractor, which stretches the opening slightly and, thus, further

increases visualization. The incision gives good exposure of the trigone, as well as of the hyperplastic tissue. It permits inspection of the bladder for associated disease and obviates the need for a preliminary cystoscopy.

Cautery is not relied on for hemostasis in any part of the operation. To control bleeding, we think it is

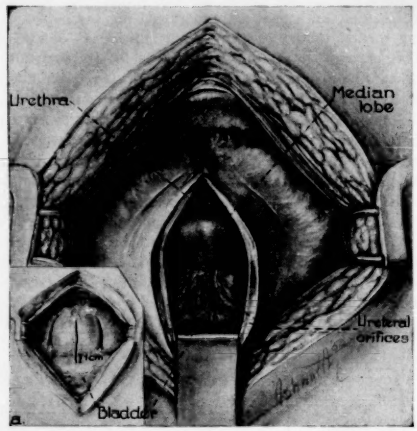

Fig. 3.—Inset *a*, line of incision in capsule and first centimeter of bladder. Main figure, exaggerated view to illustrate median lobe and trigone. At lower end of wound just above symphysis is cut edge of transversalis fascia. It is reflected over the symphysis, prostate and bladder.

imperative to have a good suction tip and forceps with long handles, a slightly curved tip and fine teeth, such as the Schnidt forceps used in tonsillectomies. With these aids bleeding can be arrested immediately with ligatures.

A tenaculum is placed on the posterior tip of the obstructing prostatic tissue, and it is retracted gently upward and distally. Then a curved incision is made in the trigone and is extended around the border of the encroaching prostatic tissue (fig. 4, inset *a*). This is done to prevent tearing of the mucosa in the region of the ureteral orifices and to allow greater facility in dissecting the prostatic tissue from the bladder neck. We often improve exposure of the bladder neck by exerting pressure on the prostate with a finger inserted in the rectum.

As the incision is carried through the mucosa to the muscle of the trigone, any vessels encountered are ligated (fig. 4). The vessels entering each lateral aspect of the prostate, noted as dissection proceeds, are also ligated. The fascia (fig. 4) covering the median lobe of the prostate, which is brought into view by the continued retraction, is incised transversely, after which enucleation of the hyperplastic tissue is continued with curved, closed scissors. In total prostatectomy this fascia is removed with the fascia enveloping the seminal vesicles.

The anterolateral plane of cleavage between the adenoma and the capsule is developed now and carried down to the apex of the prostate. The membranous urethra is cut across with scissors, care having been taken during the enucleation not to exert any pull on it. This maneuver is facilitated by the vertical capsular incision.

After the prostatic hyperplasia has been removed, a hot, wet sponge is placed in the cavity and allowed to remain for five minutes. Bleeding points subsequently encountered are ligated.

The mucosa on the posterior surface of the bladder neck is sutured to the fascia overlying the floor of the urethra with one or two interrupted plain catgut sutures (fig. 5). A Foley catheter (no. 22 is preferable to no. 24) is inserted into the bladder through the urethra, and the bag of the catheter is filled with 30 cc. of water. Care is taken to see that the bag remains in the bladder and does not get down into the prostatic bed.

The incision in the capsule and the bladder is closed with one row of interrupted plain sutures. To make sure the entire thickness of tissue is included, the sutures are started on the inner surface, carried through the capsule and fascia, first on one side, then on the other, and tied on the outside (fig. 5). To facilitate this step, a needle is threaded on either end of the suture. The bladder is now irrigated to see whether the suture line is watertight. If it is not, an additional suture is

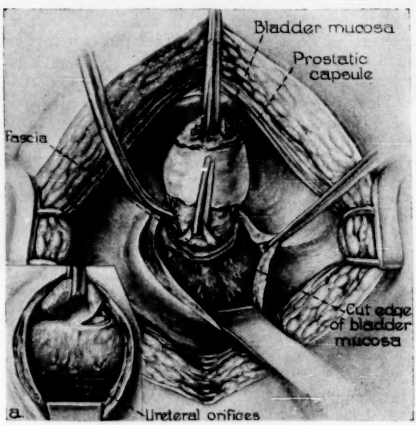

Fig. 4.—Inset *a*, line of incision through mucosa of trigone just ahead of the ureteral orifices. Note small ligated vessel. Main figure, incision about intravesical median lobe. Note ligated and clamped vessels entering lateral aspects of prostate. Allis forceps retracts fascia that is continuous with fascia enveloping the seminal vesicles. Benign glands are enucleated distal to the clamped fascia.

appropriately placed. Care is taken to insure accurate approximation of the prostatic fascia and the capsule.

The entire wound is washed with 1 pint (473 cc.) of warm water, and two Penrose drains are placed down to the depth of the wound. The only maneuver of im-

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portance in the closure is the placing of four interrupted mattress sutures through the rectus muscles and fascia. This is done to give added support to the incision and is a necessary precaution because patients are permitted to get out of bed the first postoperative day. After the

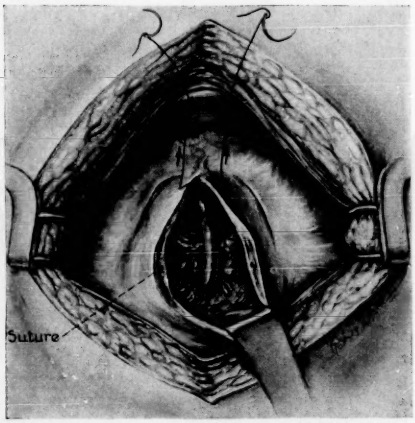

Fig. 5.—Interrupted sutures tacking down the cut edge of the bladder mucosa to the prostatic bed. Foley catheter entering the bladder. (Note: Foley bag should never be allowed to enter the prostatic cavity.) All layers of the prostatic capsule are closed with interrupted plain catgut sutures. Knots are tied on the outside.

skin incision has been closed, the vasa are ligated if the patient does not object.

When rectal examination suggests carcinoma and it is desirable to remove the posterior lamella, the prostate is elevated with a finger inserted in the rectum. Dissection is then continued posteriorly about the vesical neck to Denonvilliers' fascia. The ejaculatory ducts are severed in the process. When we do a total prostatectomy for carcinoma, we first isolate and ligate the puboprostatic ligaments. This allows greater mobility of the prostate. Any veins coursing on the anterior surface of the prostate are also isolated and tied (fig. 6). A transverse incision is then made through the endopelvic fascia surrounding the prostate, as far distal as possible, and a cuff of this fascia, just large enough to permit reconstruction of the bladder neck, is left. A catheter in the urethra, which is cut across when the urethra is divided, helps keep the membranous urethra from retracting and tearing.

The apex of the prostate is grasped with a tenaculum and pulled forward. The fascia over the rectum is thus exposed. A line of cleavage is then established in Denonvilliers' fascia, and the prostate and its capsule, along with the seminal vesicles and their enveloping fascias, are dissected free and removed in one piece. After this, the bladder and urethra are united over the Foley catheter. In making this anastomosis, we first place two layers of interrupted plain sutures posteriorly. The first layer of three or four sutures unites the muscularis and serosa of the bladder to the cuff of endopelvic fascia. The second layer unites the bladder mucosa and its underlying tissue to the urethral mucosa and its supporting structures (fig. 7). Two similarly placed layers of interrupted sutures unite the lateral and anterior margins of the bladder to the anterior margins of the cuff and urethra.

In making the anastomosis between the large lumen of the bladder and the smaller lumen of the endopelvic cuff, the excess bladder tissue is brought anteriorly and closed with interrupted plain sutures (fig. 8). The puboprostatic ligaments are then sutured to the serosa of the bladder with plain catgut. These sutures support the anastomosis and aid in fixation of the bladder. The drainage and closure of the fascia and skin are the same as those used for the less radical procedure. However, in our one case of total prostatectomy for carcinoma we instituted suprapubic, as well as urethral, catheter drainage.

Postoperative Care.—After the operation has been completed, the Foley catheter is adjusted to drain properly. The bladder is then irrigated. Irrigation is continued until all clots are removed and the urine is clear.

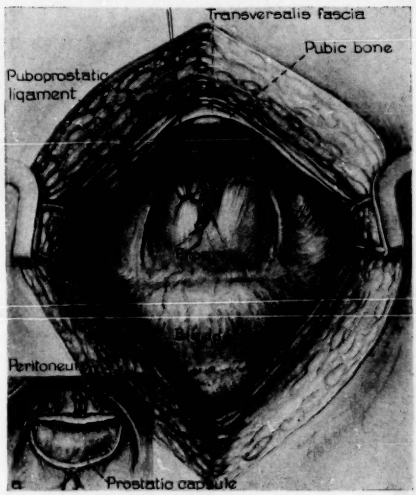

Fig. 6.—Ligature placed about one of the puboprostatic ligaments (first stage of total operation). When both are severed, the prostate is made more mobile. Superficial veins are ligated and divided. Inset *a*, incision in prostatic fascia. Note cuff for reconstructing bladder neck.

When the patient is taken back to bed, the floor nurse immediately checks the status of the catheter by irrigating the bladder with a 2 per cent boric acid solution, using a 2 ounce (59 cc.) Rebro syringe. If any clots form, she removes them. Irrigation is subsequently carried out only as necessary to insure adequate

drainage through the catheter. Bleeding may recur when the blood pressure, which is taken every hour during the first 24 hours, returns to normal. The urethral catheter is attached to sterile tubing, and the tubing is attached to a bottle. Tubing and bottle are changed daily. The bottles are cleaned with a sodium hypochlorite (purex®) solution.

Deep breathing and leg exercises are encouraged the day of operation. The day after operation the patient is allowed to get out of bed.

COMMENT

Retropubic prostatectomy can be employed for treatment of a wide variety of pathological conditions within the prostate. We have used it in management of benign hyperplasia, calculi, fibrosed tissue at the bladder neck when transurethral resection was not feasible because the urethra was small or narrowed by stricture and suspected, as well as evident, carcinoma. One of us (J. R. H.) also used the operation to correct obstruction at the vesical neck in a child.

The prostatovesical incision affords excellent exposure. Thus, it makes possible (1) accurate dissection of the vesical neck, which prevents injury to the trigone and the ureteral orifices; (2) adequate hemostasis; (3) complete enucleation or dissection of the obstructing tissue; (4) incision of the membranous urethra at the apex of the prostate without exerting traction on the urethra, and (5) exact approximation of the prostatic capsule, vesical neck and bladder.

Fig. 7.—Reconstruction of bladder neck after removal of prostate, its capsule and the seminal vesicles with their enveloping fascias. Cuff of fascia being united to posterior bladder wall. The posterior layer of sutures misses the bladder mucosa. Inset *a*, second line of interrupted plain sutures uniting bladder mucosa and membranous urethra.

Progress after retropubic prostatectomy is highly satisfactory. Our patients were able to get out of bed on the first postoperative day. There was a low incidence of bladder spasm, with resultant comfortable convalescence. Urinary control was prompt after the catheters were removed. Hospitalization was short. In most instances the urine was clear when the patient was seen in the office about a month postoperatively. There were relatively few complications, and there was no mortality.

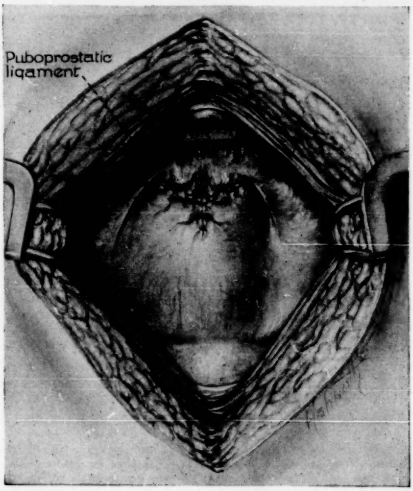

Fig. 8.—Closure completed. Note vertical closure of excessive bladder tissue and supporting puboprostatic ligaments.

We do not perform the retropubic operation on patients whose circulation would be embarrassed by the Trendelenburg position. We do not like to do it on obese men. It was our impression that an apron of abdominal fat would impair the exposure and decrease accessibility to the prostate. But we were able to get adequate exposure when we did the operation on two obese men. Nevertheless, when the patient is obese, or when he is a poor surgical risk, or when he has previously had a cystostomy, we prefer the transurethral or the perineal routes.

Up to the time of this study we favored retropubic prostatectomy chiefly because we believed that it was less likely to impair sexual potency than the perineal procedure. In view of the high incidence of diminished potency noted in this series, we have to rule out this factor, at least until such time as we can compare these results with those following other procedures.

With four prostatic operations to choose from, lack of a method of treatment is not the problem in disease of the prostate. If we are to increase the incidence of cure in carcinoma of the prostate, we must, as is frequently stressed, make the diagnosis earlier. This study,

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like one made previously,[2] draws attention to the fact that unilateral firmness of the prostate and asymmetry are earlier clinical signs of malignant changes than a nodule.

The diagnosis in our eight cases of relatively early lesions was not established, as has been pointed out, until fixed sections were studied. As far as we can determine now from our records, frozen sections were made in two cases. The report in one was "negative"; in the other, "early carcinoma." In the latter case, as well as in the other seven, we believed, as has also been stated, that all the suspicious tissue had been removed.

Evaluation of the findings in these eight cases, as well as our observations in other studies [14] and those of Moore,[15] who found that 73.5 per cent of carcinomas arose in the posterior lamella, emphasizes our growing conviction that the posterior lamella should be removed routinely when clinical findings suggest carcinoma and exploration leaves doubt concerning the presence of malignant growth (fig. 1). It would seem, also, that consideration should be given to removal of the posterior lamella as a prophylactic measure in elderly men subjected to prostatectomy for urethral obstruction. The situation here would be analogous to that in removing the cervix when a hysterectomy is done.

In the future we expect more help from frozen section studies. In view of our difficulty in removing suspicious tissue that proved to be carcinomatous (four cases), we should in similar circumstances be inclined to consider total prostatectomy, even though the frozen section report was negative, provided the patient's age and general condition were no contraindications.

SUMMARY

One hundred cases of retropubic prostatectomy are analyzed. There were no deaths, and there was no instance of permanent incontinence or osteitis pubis.

Of 84 patients who answered a questionnaire relative to sexual potency, 34 replied they had noticed diminution in potency prior to the retropubic prostatectomy. Twenty noticed improved sexual potency postoperatively. Of 50 men who had had good sexual function before the operation, 25 noticed diminished function afterward.

The incidence of carcinoma in this series was 13 per cent. Five patients had extensive and eight had relatively early lesions.

Attention is called to such early suggestive clinical signs of malignant change as asymmetry and unilateral firmness of the prostate.

A prostaticovesical incision that extends from midway in the capsule through the first centimeter of the bladder is described. Carrying the incision through the bladder neck does not cause any more distress than a capsular incision, nor does it delay healing.

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SERUM PHOSPHATASE DETERMINATIONS IN DIAGNOSIS OF PROSTATIC CANCER

A REVIEW OF 1,150 CASES

Reed M. Nesbit, M.D.
and
William C. Baum, M.D., Ann Arbor, Mich.

Serum phosphatase determinations have become important aids in diagnosis, particularly the diagnosis of prostatic cancer, but there has been no clear understanding regarding the interpretation of these tests under various conditions that are met clinically.

Acid phosphatase is an enzyme which is found only in the epithelial cells of the prostate gland in sexually active men and in the cells of prostatic cancer. Normally there is a small amount of this substance in the blood serum. The enzyme owes its existence to the sustaining influence of the male sex hormone, and for this reason it has been termed a chemical secondary sex characteristic. After castration it disappears from the prostatic epithelium, and a coincidental shrinkage of the tissues occurs. This phenomenon was utilized advantageously in the treatment of prostatic carcinoma by Huggins, whose investigations inaugurated a new era in cancer research.[1]

It is well established that sustained elevation in the serum acid phosphatase level occurs only when metastases from prostatic cancer have involved the bone marrow and lymph nodes.[2] Investigations have shown that transient elevations in the serum titer of this enzyme may be detected after the trauma of operation on the prostate gland [3] and subsequent to digital manipulation,[4] but not as the result of prostatitis, benign prostatic hypertrophy or tumor metastatic to the prostate from other organ structures.[5] Thus, sustained abnormal elevations of this enzyme are pathognomonic of metastatic prostatic carcinoma.

Alkaline phosphatase is produced by bone as an essential agent for growth and repair. With few exceptions its serum level reflects bone activity in the absence of liver disease. An elevation in the serum level is not specific for prostatic cancer, for such elevations may be found in metabolic disease of bone and as a result of abnormalities of liver function. However, in the presence of known metastatic prostatic carcinoma its elevation may signify osteoblastic response to invading tumor and in this way serves as an

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index of the extent of such activity. When elevations are present in cancer of the prostate, the serum level of the alkaline phosphatase is generally higher than that of the acid phosphatase. After castration, when remission occurs, the acid phosphatase level promptly drops to normal, whereas there is a temporary rise in the alkaline phosphatase value, followed later by a drop toward the normal level. This behavior affords the clinician a chemical index of the effectiveness of treatment. Furthermore, it has been a helpful aid in the diagnosis of certain borderline cases. For example, a patient is found to have a normal serum acid phosphatase but an elevated alkaline phosphatase. Roentgenograms reveal no evidence of bony metastases, and digital examination of the prostate gland is indeterminate. The elevated serum alkaline phosphatase can be ascribed to cancer of the prostate gland if the administration of diethylstilbestrol in therapeutic doses results

TABLE 1.—*Incidence of Elevated Serum Acid Phosphatase in Patients with Prostatic Carcinoma Both in the Presence and in the Absence of Metastases on Admission*

	Total Number of Patients	Number of Patients with Elevated Serum Acid Phosphatase	Per Cent of Total
No metastases on admission.....	656	135	20.5
Metastases on admission.....	495	324	65.5
Entire series with and without metastases	1,150	459	39.9

TABLE 2.—*Incidence of Elevated Serum Alkaline Phosphatase in Patients with Prostatic Carcinoma Both in the Presence and in the Absence of Metastases on Admission*

	Total Number of Patients	Number of Patients with Elevated Serum Alkaline Phosphatase	Per Cent of Total
No metastases on admission.....	544	145	26.6
Metastases on admission.....	560	485	85.8
Entire series with and without metastases	1,104	626	56.7

in a further rise in the serum value. However, a negative response to the test, although substantial evidence against cancer of the prostate, would not be determinative.

Physicians who have utilized these two tests in diagnosis and clinical management of prostatic cancer have often been surprised that patients with extensive metastases sometimes are found to have normal serum phosphatase levels, while some patients with no evident bone or lymph node extension have had unexpected elevations in these values. The frequency of these apparent clinical paradoxes has led physicians to speculate regarding their implications and to wonder whether the tests might prove in the final analysis to be of dubious value in their clinical application.

6. The normal range and abnormal variations for serum phosphatase levels were established on the basis of criteria accepted by the individual clinics cooperating in the present study. While originally this method of serum analysis was thought to preclude satisfactory comparison of results, actually the diversity of technic offers a cross section of standard urologic practice and, in reality, is more suitable for a true evaluation of a generally used diagnostic test as it is actually employed than if the study were limited to one method used by a single clinic.

The present study was made in the hope that some of these questions might be clarified. It was felt that data on a large group of patients known to have prostatic cancer and followed for significant periods would provide a secure basis for evaluation.

SCOPE OF STUDY [6]

There were 1,150 proved cases of prostatic cancer included in this series. The data have been assembled in tables and enumerate the following:

1. The specificity of serum alkaline and acid phosphatase determinations in the diagnosis of prostatic carcinoma

2. The prognostic implications of an elevated serum acid phosphatase level in the absence of demonstrable metastases on the first admission

3. The clinical significance of a normal serum acid phosphatase level in the presence of metastases

ANALYSIS OF DATA

Specificity of Serum Phosphatase Determinations.—Table 1 shows the incidence of elevated serum acid phosphatase in patients with proved prostatic carcinoma. An examination of these statistics reveals the following facts: In less than 40 per cent of the entire 1,150 cases there were significant elevations in serum acid phosphatase on the first admission. As would be expected, patients with evidence of metastases on original examination demonstrated the closest correlation between clinical findings and expected laboratory results. Sixty-five per cent of these patients were found to have an elevated serum titer of this enzyme, while those without metastases provided the greatest discrepancy in this regard, for 20 per cent of such patients had significant elevations in serum acid phosphatase. These findings indicate that an elevation of the acid phosphatase blood level constitutes substantial evidence in favor of a diagnosis of metastatic prostatic carcinoma, and that normal levels are usually found in the absence of spread. However, normal levels of acid phosphatase do not exclude the possibility of metastases, for 35 per cent of those with recognized extension of their neoplasm to lymph nodes or bone had a normal serum titer of this enzyme on first examination. One may speculate that the apparent contradiction offered by the association of a normal blood phosphatase level with metastases, or of an elevated serum level with the absence of metastases, is due, in the first instance, to a failure on the part of the carcinomatous cell to produce this enzyme, either through anaplastic change or through some unknown factor in its pathological physiology, and, in the latter case, to a lag or delay between the rise in serum titer and the appearance of osteoblastic response on the part of bone to invading tumor.

Table 2 presents the same data with regard to serum alkaline phosphatase determinations. From an examination of these statistics it appears that essentially the same statements can be offered regarding the specificity of this test as a diagnostic aid in prostatic cancer as were made concerning the value of serum acid phos-

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phatase determinations. The correlation of those who presented elevations in the blood level of alkaline phosphatase and, at the same time, evidence of metastases would seem to be even closer than with the serum acid phosphatase values: almost 86 per cent of these patients had significant elevations in the serum titer of this enzyme.

Prognostic Implications of Elevated Serum Acid Phosphatase in the Absence of Metastases.—Table 3 demonstrates the value of serum acid phosphatase as a prognostic aid in the evaluation of patients with prostatic cancer. Given two groups of patients, both free from roentgenologic evidences of metastases, but one selected on the basis of an abnormal or elevated serum level and the other on the basis of a normal serum titer, we may predict that the group with the normal level will have a far greater opportunity for three year survival than with the group found to have an abnormal level on first admission. This supports the view that an

TABLE 3.—*Clinical Significance of Elevated Serum Acid Phosphatase in Patients with No Evidence of Metastases*

	Total Number of Patients	Patients Dead of Prostatic Cancer Within Three Years	
		Number	Per Cent
Normal serum acid phosphatase on first admission	194	67	34
Elevated serum acid phosphatase on first admission	87	52	60

TABLE 4.—*Clinical Significance of Normal Serum Acid Phosphatase in Patients with Metastatic Prostatic Carcinoma*

Serum Acid Phosphatase	Total Number of Patients	Per Cent Three Year Survival (Entire Group)	Per Cent Three Year Survival in Patients Benefited by Endocrine Therapy		Per Cent Three Year Survival in Patients Refractory to Endocrine Therapy	
			Number	Per Cent	Number	Per Cent
Normal	122	32.5	82	60	40	5
Elevated	256	25.0	122	47	134	3

elevated serum acid phosphatase indicates spread of the neoplasm, even though other evidences of metastases are lacking.

Clinical Significance of Normal Serum Acid Phosphatase in the Presence of Metastases.—It has previously been observed that some patients who suffer terminal relapse do not have elevations in the serum acid phosphatase values, a phenomenon generally ascribed to acquired androgen independence on the part of the neoplasm. In the present series there were 122 patients with bony metastases who had normal values at the time of diagnosis. Of these patients 32.5 per cent enjoyed a three year survival, and 60 per cent of them were benefited by endocrine treatment. The clinical response in this group was in the aggregate more favorable than among 256 patients exhibiting elevated serum acid phosphatase. Twenty-five per cent of this group of patients survived for three years, and 47 per cent of the total were benefited by therapy. Thus, a normal serum acid phosphatase level associated with metastases in untreated prostatic cancer does not indicate androgen independence, nor is the prognosis adversely affected by this finding.

CONCLUSIONS

The gland cell of prostatic cancer possesses the physiological capacity for the production of the enzyme acid phosphatase. Significant blood serum elevations of this substance are found to occur only when the tumor has spread to lymph nodes or bone marrow spaces. For this reason an elevation of the serum level is pathognomonic of metastatic prostatic neoplasm, but a normal serum titer does not exclude the disease.

A small percentage of patients who had prostatic cancer with metastases were observed to have normal serum levels of acid phosphatase; on the other hand, some patients with no roentgenologic evidence of metastases were found to have significant elevations of the serum titer of this enzyme.

The discovery of an abnormal serum acid phosphatase level in the absence of evident metastases in a patient with prostatic cancer carries with it the implications of poor prognosis, for the patient with this finding has considerably less chance for three year survival than does the person in the same circumstances whose serum acid phosphatase is normal.

The finding of a normal serum acid phosphatase value in a patient with metastatic prostatic carcinoma does not necessarily imply poor response to endocrine therapy by reason of the assumption of androgen independence on the part of the cancer cell, for, in general, these patients exhibit the same, or a greater, degree of benefit from treatment than do patients who have an elevated serum acid phosphatase level.

The level of serum alkaline phosphatase is but a reflection of osteoblastic activity in the absence of liver disease and is not in itself specific for prostatic carcinomatous activity. In the presence of metastases it serves as a guide to the extent of spread of the primary tumor and the nature of response to treatment.

ABSTRACT OF DISCUSSION

DISCUSSION OF PAPERS BY DRS. HAND AND SULLIVAN AND DRS. NESBIT AND BAUM

DR. ELMER BELT, Los Angeles: I wish to ask Dr. Baum if in the absence of other signs of prostatic cancer he can rule out prostatic cancer bone metastases by means of the alkaline and acid phosphatase determinations in patients in whom roentgenograms show patchy thickening of the bone cortex in some and rarefaction of the bone cortex in others. Does his study help differentiate Paget's disease (osteitis deformans) from prostatic cancer metastases through elevation of the alkaline phosphatase in Paget's disease? Dr. Hand's thoroughgoing effort to solve and to modify satisfactorily the new operative technic of retropubic prostatectomy is impressive. I appreciate especially his combination of the approach through the anterior bladder wall and entry through the anterior capsule of the prostate gland for enucleation of benign adenomas. The illustrations show that in the radical removal of the prostate by this route of Dr. Hand seminal vesicles and ampullae are left behind. Is this a true interpretation of the technic presented? These tissues and their surrounding sheaths are invaded early in prostatic cancer. Should not an extra effort be made to remove them? Dr. Hand's contol by suture of the vessels which enter the prostate from the trigone and vesical neck is a sound surgical procedure. This is one of the points of failure in the operation as pre-

viously described. May I tempt Dr. Hand into a statement of preference? Has his careful study of this material in his wide experience made him prefer this method over perineal prostatectomy in which he has attained such skill? Will Dr. Hand enlighten us further in regard to recognition of cancer? If he has felt a hard lump in the posterior capsule of the prostate before operation, can he do a biopsy of this lump for guidance during his operation before completely enucleating the suspected gland by his retropubic method? Will Dr. Hand tell us what he has learned regarding the preservation of sexual power after the removal of benign prostatic adenomas and after the more total removal by retropubic prostatectomy for prostatic cancer? These are points in which all of us are interested.

DR. THOMAS R. MONTGOMERY, Portland, Ore.: The fact that Dr. Hand and I practice in the same city and in the same hospital enables me to discuss his excellent paper with greater authority. I have several times watched him do the modification of retropubic prostatectomy. It is not the rapid half-hour procedure described by Millin, Bacon and others, but rather a tedious, careful, sharp dissection under direct vision, combining suprapubic and retropubic procedures. Much of the dissection of median lobe and posterior lamella is done with one finger in the rectum affording countersupport and orientation. Why does Dr. Hand expend this extra time and effort? I believe it is because he feels that removal of the posterior lamella will leave his patients with less chance of recurrence of obstruction. More important, he may be removing the future site of development of prostatic carcinoma. Some of the lesions he treats in this way would generally be attacked by others by transurethral resection. Where question of prostatic carcinoma exists, I believe perineal exposure affords better access for the taking of a biopsy specimen and total radical prostatectomy if biopsy is positive. This phase of the discussion has been well covered by Dr. Belt. Dr. Hand's modification is essentially an incomplete subtotal prostatectomy done through a midline incision in the prostatic capsule extended into the anterior wall of the bladder. He may later be able to report a reduced incidence of prostatic cancer in previously prostatectomized patients treated in this manner. These patients have no greater postoperative discomfort than those in whom the incision is confined to the prostatic capsule, as advocated by Millin. The paper of Drs. Nesbit and Baum I found most interesting. It is unfortunate that serum acid phosphatase determinations cannot be relied on more heavily as a guide to operability in prostatic cancer, as well as an indicator of recurrence after radical surgical resection. We are still using the determinations at the University of Oregon in this manner. A study of our results has not been made, but from my own private experience clinical digital evaluation unfortunately still stands pretty much alone and unaided.

DR. JOHN R. HAND, Portland, Ore.: One of the things we tried to do was to find a way in which to evaluate more accurately the minimal atypical changes noted in the prostate on rectal examination. Of the 100 men in our series, five had clinically advanced carcinoma and 21 had minimal suggestive signs of carcinoma. The suggestive clinical findings of 13 patients proved to be due to calculi, fibrosis and other nonmalignant disease. But the other eight patients proved to have relatively early carcinoma. We also tried to determine how we could have improved our management of the eight patients with early neoplasms. In each patient it had been necessary to remove the posterior lamella to get all the suspicious tissue, and the diagnosis was not established until fixed sections had been studied. In four patients the gland could be shelled out easily; in the other four it had to be dissected in pieces. In view of these findings, we would, in the future, consider total prostatectomy even without a confirmatory frozen section diagnosis of carcinoma if we were to encounter similar difficulty in removing suspicious tissue. In the radical procedure, the prostate and its capsule together with the seminal vesicles and their enveloping fascias are removed in one piece. This stage of the operation has been completed in the illustrations to which Dr. Belt referred. In answer to Dr. Belt's question regarding biopsy, if the patient has no symptoms of urinary obstruction, we do a perineal biopsy. If he has urinary obstruction we determine the type of protatectomy best suited for him and remove tissue for biopsy when we do the prostatic operation. In regard to whether I prefer retropubic prostatectomy to other types, I should say no. While I am favorably impressed with the results of the retropubic operation in this series and in that of others, I believe there is a place for the other prostatectomies and that the condition of the individual patient should determine which type is carried out. With regard to sexual function, it is a difficult factor to evaluate, particularly in elderly men. Of 84 men who answered our question regarding sexual function following retropubic prostatectomy, 71 had benign and 13 had malignant lesions. Twenty-seven (38 per cent) patients with benign lesions had diminished potency prior to operation. After operation potency improved in nine and remained unchanged in 18. Seven patients (54 per cent) with malignant lesions had had diminished potency preoperatively; none showed postoperative improvement. Forty-four patients with benign lesions had had good preoperative potency. After operation, 23 (52 per cent) had diminished potency, 11 continued to have good potency and 10 had better potency. Six patients with carcinoma had had good potency prior to operation. After operation, two (33 per cent) had diminished potency, three continued to have good potency and one had better potency. One of the patients with good postoperative potency and the one with improved potency had not had either diethylstilbestrol or orchiectomy. The extent of the carcinoma appears to be a factor in lessened sexual function. Of the five men with seminal vesicle involvement, four had had diminished potency prior to operation, and the one who had had good preoperative potency had diminished potency after operation. As to incontinence, one man with advanced carcinoma had temporary incontinence of four months' duration following partial retropubic prostatectomy.

DR. WILLIAM C. BAUM, Ann Arbor, Mich.: In response to Dr. Belt's question concerning the case presenting evidence of bony change suggestive of carcinoma but in which Paget's disease or some disease of the bone cannot be ruled out, and in which the alkaline phosphatase and acid phosphatase are at normal levels, I can state only that the use of endocrine therapy in the form of diethylstilbestrol has been somewhat effective. Doses of 1 to 5 grains (0.06 to 0.32 Gm.) of diethylstilbestrol given over a period of one month in those cases in which the change is due to carcinoma are usually associated with a subsequent rise in alkaline phosphatase and a drop after healing takes place. However, this does not occur in all cases of carcinoma. If carcinoma should be resistant to the therapy used, you may not see such a change, so that this is applicable only in those cases in which endocrine therapy will be of benefit.

Practical Men.—There are, of course, in every calling, those who go about the work of the day before them, doing it according to the rules of their craft, and asking no questions of the past or of the future, or of the aim and end to which their special labor is contributing. These often consider and call themselves "practical men." They pull the oars of society, and have no leisure to watch the currents running this or that way; let theorists and philosophers attend to them. In the meantime, however, these currents are carrying the practical men, too, and all their work may be thrown away, and worse than thrown away, if they do not take knowledge of them and get out of the wrong ones and into the right ones as soon as they may. . . . It is not only going backward that the plain practical workman is liable to, if he will not look up and look around; he may go forward to ends he little dreams of. . . . And so, with subtler tools than trowels or axes, the statesman who works in policy without principle, the theologian who works in forms without a soul, the physician who, calling himself a practical man, refuses to recognize the larger laws which govern his changing practice, may all find that they have been building truth into the wall, and hanging humanity upon the cross.—Oliver Wendell Holmes, Currents and Counter-Currents in Medical Science, Boston, Ticknor and Fields, 1861.

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RECENT ADVANCES IN TREATMENT OF MIGRAINE

Arnold P. Friedman, M.D.
and
Theodore J. C. von Storch, M.D., New York

Treatment of migraine has posed a problem for many years. Its severity and the tenacity of the symptoms have caused much concern to doctor and patient alike. The number and multiplicity of therapeutic agents and the uniformly good results reported with these medicaments indicate the unsatisfactory state of knowledge concerning treatment.

The underlying causes of migraine are at present unknown. In fact, it is doubtful whether any single process or mechanism is responsible. Among the many theories that have been advanced, the vasomotor has long been popular. More than 70 years ago Dubois-Reymond [1] ascribed the symptoms of migraine to tonic spasm of the muscular coats of the vessels. In recent years Wolff [2] and his co-workers have objectively demonstrated a vasomotor imbalance involving spasm and dilatation. At present, most investigators explain the prodromes, course, symptoms, signs and sequelae of the disorder on the basis of changes in the cerebral and meningeal circulation. Proponents of the vascular theory believe that an initial vasoconstriction of the cerebral arteries produces visual and possibly other preheadache phenomena prior to the onset of the headache. This prodromal period is then followed by dilatation and distention of cranial arteries, primarily in the distribution of the external carotid artery. It is this arterial dilatation that is presumed to cause the headache. However, we are aware that arterial dilatation and edema are in themselves insufficient for production of pain. There must be other, more basic, factors which cause the dilatation and which alter the sensitivity of the blood vessel and its periarterial plexus. We do not know what these factors are.

One popular concept has associated the various migraine phenomena with abnormalities in the endocrine system. Disorder of the pituitary, gonads, adrenal glands and thyroid have all been suggested as a cause of headache. There still remains a great deal to be known about the relation of migraine to endocrine equilibrium.

Other investigators have proposed vitamin and dietary insufficiencies, allergic conditions, neurosympathetic disturbances, fluid imbalance and toxic, colonic, duodenal and hepatic disorders, as well as various ocular malfunctions, and even trauma to the head and neck. Evidence to support such hypotheses is meager.

The great variety of theories which have been proposed indicates how incomplete is our knowledge of the basic cause of the migraine attack.

The importance of psychological factors in migraine has long been recognized.[3] Personality studies indicate that a great majority of patients have certain common characteristics. However, these are not pathognomonic of migraine, or associated with migraine alone. In some cases, these factors may call forth pernicious emotional reactions, precipitating an attack of migraine, while in other cases it is quite likely that the trigger mechanism is an allergic, endocrine or metabolic factor.

Treatments based upon these various theories are remarkable for their consistent therapeutic success. For example, certain allergists report that between 50 and 80 per cent of patients treated are cured or considerably improved. Ophthalmologists have stated that correction of refractive errors has resulted in considerable improvement in over 90 per cent of the patients. Other workers report improvement with histamine desensitization or with elimination diets in 50 to 70 per cent of cases. Endocrinologists note excellent results with various hormone treatments, and some internists report equal success with thiamine chloride, calcium, potassium or changes in oxygen tension. Reports from orthopedists have indicated "successful" treatment of migraine by use of cervical traction in 85 per cent of their cases. On the other hand, Wolff and his co-workers state that two persons out of three can be helped by modification of stress in the patient's relation to his environment.

Such inconsistency must be based on a variety of factors. First of all, were the treated subjects really suffering from migraine? In any evaluation of migraine it is obviously imperative to differentiate this form from other types of chronic headache. We feel that it is important to stress this fact because of the regrettable tendency in everyday medical practice, and to some extent in the medical literature as well, to apply the term migraine to any chronic, recurring headache. While there may well be similarities between migraine and other types of headaches, the similarities are more than outweighed by important differences, particularly in the physiological mechanism of the individual attack. A careful history, physical and neurological examinations, certain ancillary tests and thorough psychological study of the patient will help to make this differentiation possible.

The criteria for the diagnosis of migraine must include several of the following factors:

1. Recurrent headache, usually throbbing and unilateral at onset, occurring against a background of relative well-being.

2. Temporary visual disorders preceding the headache, such as scintillating scotomas, photophobia, hemianopsia and blurred vision.

Dr. Aaron Koblentz aided in this study at the Veterans Administration, Brooklyn.

Read before the Section on Nervous and Mental Diseases at the Ninety-Ninth Annual Session of the American Medical Association, San Francisco, June 29, 1950.

The material in this study is from the Headache Clinic of the Division of Neuropsychiatry, Montefiore Hospital for Chronic Diseases and the Headache Clinic Section, Mental Hygiene Service, Veterans Administration, Brooklyn and New York.

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Attending Physician, Division of Neuropsychiatry, Montefiore Hospital for Chronic Diseases; Assistant Professor of Clinical Neurology, Columbia University College of Physicians and Surgeons; Area Consultant in Neurology, Veterans Administration, New York (Dr. Friedman). Chief of the Division of Neuropsychiatry; Professor of Clinical Neurology, Columbia University College of Physicians and Surgeons (Dr. von Storch).

1. DuBois-Reymond, E.: Zur Kenntniss der Hemikrania, Arch. f. Anat., Physiol. u. wissensch. Med. 1860, p. 461.

2. Graham, J. R., and Wolff, H. G.: Mechanism of Migraine Headache and Action of Ergotamine Tartrate, A. Research Nerv. & Ment. Dis., Proc. **18**: 638, 1938.

3. Friedman, A. P.; Brenner, C., and Merritt, H. H.: Management of Patients with Chronic Headache, J. A. M. A. **132**: 498 (Nov. 2) 1946.

3. Nausea, vomiting and irritability, occurring at the height of the attack.

4. Personality characteristics of inflexibility and shyness in childhood, giving rise to adult perfectionism, rigidity and resentment, ambitiousness and often efficiency.

5. A history of migraine in the immediate family.

6. Less frequent symptoms, such as paresthesias, speech disorders, dizziness, sweating and other vasomotor disorders.

7. Relief by ergotamine derivatives in about 85 per cent of the cases.

Other reasons for discrepancies in the literature are failure to differentiate between prophylactic and symptomatic treatment, unsatisfactory control of the medications, inadequate dosage, limited observation of results, use of relatively small groups of patients and, last, but not least, personality differences in the doctor-patient relationship.

About four years ago, it was decided to evaluate the therapy of migraine under control conditions. Accordingly, headache clinics were organized at the Montefiore Hospital and in the New York regional offices of the Veterans Administration. From these sources we were able to treat and observe a group of 604 patients

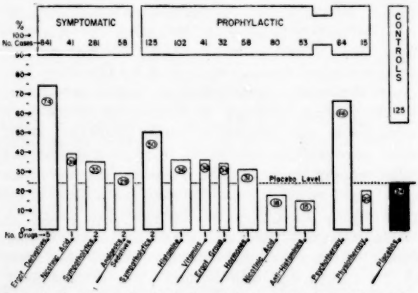

Chart 1.—Percentage of patients improved by various drugs and methods.

for a period of one to four years. During this study a variety of therapeutic approaches was investigated.[4]

It is not our purpose in this paper to discuss all of our examinations and observations on these patients; rather, we wish to focus on our therapeutic results.

In the treatment of migraine the physician has four main methods which can be used, either alone or in combination: pharmacotherapy, physical therapy, surgery and psychotherapy. He may merely offer symptomatic relief or strive to prevent the recurrence of the headaches. The latter is obviously the ideal, but most therapy to date falls short of this goal.

Previous observations had indicated that this study should be directed toward the evaluation of various pharmacological agents and of psychotherapy.[5] Therefore, in this report the emphasis has been placed on these two factors. Analysis of the study is summarized in charts 1, 2 and 3, and in tables 1 and 2.

4. It should be pointed out that, in most cases, the patient who came to the headache clinic attended the clinic because of persistent and pernicious migraine headache.

5. Friedman, A. P., and Brenner, C.: Treatment of the Migraine Attack, Am. Pract. 2: 467, 1948.

6. Each tablet of cafergot contains 1 mg. ergotamine tartrate U. S. P. and 100 mg. caffeine.

It is important to note that in symptomatic therapy 20 per cent of the patients were relieved by placebos. Hence, this factor must be considered in evaluation of all other therapies.

Chart 1 indicates that in symptomatic treatment ergotamine and its derivatives are distinctly superior to

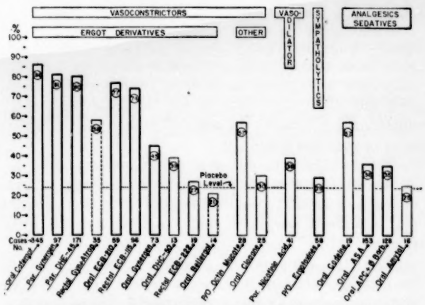

Chart 2.—Percentage of patients improved by symptomatic medication.

all other types of drugs we have tested. These reports are in accordance with current opinion—that the ergotamine group is unequaled in the symptomatic treatment of migraine. As indicated on chart 2, the most effective medication for relief of a migraine attack is oral use of cafergot [6] (improvement in 86 per cent). Given parenterally, ergotamine tartrate and dihydroergotamine were of value in 80 per cent of cases. Combinations of caffeine, bellafoline® (combination of malic acid salts of the total levorotatory alkaloids of belladonna leaves) and ergotamine tartrate U. S. P. (gynergen®) used as rectal inserts were efficient in 76 per cent of cases. All these preparations were more effective than adminis-

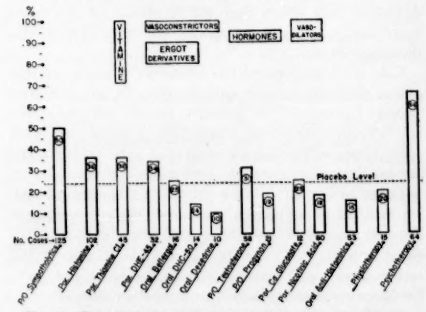

Chart 3.—Percentage of patients improved by prophylactic methods.

tration of ergotamine tartrate by the oral route, which gave good results in only about 45 per cent of cases. This is in accord with previous reports in the literature.

Comparison of therapeutic results with various drugs in the same patient was carried on throughout the study, confirming the results indicated in the charts. For example, the following comparisons were obtained in a sample group of 93 patients using cafergot orally. The effect of cafergot was compared in the same patient

with that of orally administered ergotamine tartrate (gynergen®) in 20 patients; of dihydroergotamine, given parenterally, in 23 patients; of an oral analgesic (acetylsalicylic acid) in 35 patients and of an orally administered vasodilator (nicotinic acid) in 15 patients. In these patients orally administered cafergot was about as efficient as parenterally administered dihydroergotamine. It was more effective than orally administered ergotamine tartrate. Cafergot was distinctly better than an oral analgesic. It was also more effective than nicotinic acid.

It should be noted that, on preliminary trial, other vasoconstrictors, such as octin® (N,1,5-trimethyl-4-hexenylamine) mucate and clopane (cyclopentamine hydrochloride), were useful in only an occasional patient (57 and 30 per cent, respectively).

Our results with vasodilators (nicotinic acid), sympatholytics (DHO-180 and CCK-179) and simple analgesics indicate that these drugs are not very helpful, the first two giving good results in 39 and 29 per cent of cases. Meperidine (demerol®) hydrochloride U. S. P. and codeine were moderately effective analgesics, giving relief in 63 and 57 per cent of cases, respectively. Previous experience has indicated that they give some relief in the late stages of a migraine attack.[6a]

Further analysis of the best symptomatic treatment, i. e., ergotamine derivatives, is shown in table 1. The use of ergotamine derivatives by injection often increases the incidence of nausea and vomiting. A few patients cannot tolerate oral medication. In these the drug may be given by rectal inserts in order to avoid unpleasant reactions.

As will be seen from table 2 and chart 3, attempts to prevent the occurrence of headache entirely were less successful. Psychotherapy was the method of greatest value (effective in 66 per cent). Such therapy, as practiced by our group, consists of analytically oriented interviews by trained psychiatrists, without, however, any attempt at formal analysis. Maintenance of improvement by psychotherapy has been sustained over a period of two to four years. A large number of these patients will respond satisfactorily to the type of psychotherapy which is well within the province of the general practitioner.

The use of sympatholytics (DHO-180 and CCK-179) has shown some promise in the prevention of migraine (in 50 per cent of cases). However, these results in most cases are based on observations of no more than one year's duration.

Histamine administered by intravenous infusions or subcutaneous injections was not as effective in our hands, being effective in 36 per cent, as reports from the literature might indicate.

Such forms of therapy as nicotinic acid, thiamine chloride, testosterone and antihistaminics were tried, with little success.

Physical therapy (heat, massage and traction) was used in only 15 patients. The results were unsatisfactory.

Because of the recent publications on "cervical migraine," [7] roentgenograms of the cervical portion of the spine were obtained of 50 patients. Evidence of pathologic condition in this region was found in only one case.

Our experience with surgical procedures has been limited. Dr. Leo Davidoff, who was previously associated with the clinic, stated that in his experience surgery is of little value for relief of migraine except in cases in which the pain is localized in a specific segment of the artery. Ligation of these vessels has given some relief in six cases. Similar results were reported by von Storch and others. Rowbotham,[8] in an analysis of 50 cases, recommended arterial ligation, trigeminal section and sympathectomy, each for a specific type of headache. His results have not been uniformly successful. In certain cases in which vascular disease and the like do not allow specific treatment for the migraine headache, we have recommended ligation or periarterial infiltration of the artery in the region of the headache.

TABLE 1.—*Best Symptomatic Treatment*
(Vasoconstrictors)

Medication	Composition	Route	Dosage	No. Cases	Results, % Poor	Fair	Good	Improved*
Cafergot	Gynergen® + caffeine	Oral	2-1-1 ½ hr. apart	345	14	23	62	86
Gynergen®	Ergotamine tartrate	Parenteral	0.5 mg. sc.	97	19	44	37	81
ECB-115	Cafergot + bellafoline® + double amt. gynergen®	Rectal	1-1-1 ½ hr. apart	96	26	18	61	74

* Total percentages of fair and good (tables 1 and 2).

TABLE 2.—*Best Prophylactic Treatment*

Method or Medication	Composition	Route	Dosage	No. Cases	Results, % Poor	Fair	Good	Improved
Psychotherapy	.....	.....	.....	64	34	27	39	66
Sympatholytics	.....	Parent. oral	1 mg. I.M.-I.V. 6 tab./day	125	50	34	16	50
DHO-180, CCK-179*	Dihydroergocornine							
Histamine	Histamine diphosphate	Parent. I.V.	2.75 mg. per 250 cc.	102	64	11	25	36

* CCK-179 is a mixture of equal parts of hydrogenated ergot alkaloids named dihydroergocornine (DHO-180), dihydroergocristine (DCS-90) and dihydroergokryptine (DKH-135).

SUMMARY

It is our impression that the treatment of migraine is a complex, individualized procedure. Symptomatic treatment is essentially one of pharmacotherapy, and the best results have been obtained with the use of the ergotamine derivatives, notably a compound of ergotamine and caffeine (cafergot).

Prevention of an attack is best accomplished by psychotherapy. However, the use of certain sympatholytic drugs holds promise.

The treatment of migraine has now reached a point where, in most instances, the practitioner can favorably modify the frequency and severity of the patient's headache.

6a. Friedman, A. P., in Conn, H. F.: 1949, Current Therapy, Philadelphia, W. B. Saunders Company, 1949.
7. Bartschi, W.: Migraine Cervicale, Bern, Hans Huber, 1949.
8. Rowbotham, G. F.: The Surgical Treatment of Migraine, in IV^e Congrès Neurologique International: Rapports, Paris, 1949, vol. 1, p. 147.

ABSTRACT OF DISCUSSION

DR. CARO W. LIPPMAN, San Francisco: I agree with Dr. Friedman that the ergotamine products relieve the individual attacks more successfully than any other drug. In 19 years of work with migraine, I have used the same rigid criteria for diagnosis that Dr. Friedman employs. However, I have not been interested in the individual headache attacks. I have sought to alter the course of the condition so that headaches and other symptoms are separated by longer and longer intervals and, in some cases, disappear entirely. In the first 10 years of my work I treated only patients in whom gynergen® had failed completely or, in rarer cases, had produced addiction. I have always considered migraine an inherited disturbance of the body chemistry. Because of the usual disappearance of migraine headaches during pregnancy, I thought that estrogen or its allied steroids might reverse this chemical disturbance and relieve the condition. From 1931 to 1934 the preparations were not potent enough. In 1934 I started to treat women with estradiol benzoate U. S. P., using ampules of 1.66 mg. in sesame oil, equivalent to 10,000 rat units, or 50,000 international units. The headaches became less frequent and less severe. The headache appeared on the seventh, fourteenth, twenty-first and twenty-eighth days. The headaches of the seventh and twenty-first days were mild; those on the fourteenth day were moderately severe, and the headache of the twenty-eighth day was very severe. After a month or two of treatment, the headache on the seventh and twenty-first days disappeared; that on the fourteenth day became mild, and the headache of the twenty-eighth day, though exceedingly severe, was shorter in duration. After another few months of treatment, only the very severe headache of the twenty-eighth day developed. However, the attack was of still shorter duration, and in rare cases disappeared entirely. Of course, I have had many failures, too. I customarily give 20 to 30 ampules of estradiol benzoate within the first four weeks. Then I give a maintenance dose according to the age of the patient and the severity of the case. During the first years of experimentation the patients were checked with many varieties of placebos or by discontinuance of the treatment for weeks or months. When the symptoms returned, they would again disappear with resumption of steroid injections. I sometimes carried out these checks on an individual patient for two or three years. The great advantage to the physician in recognizing the rhythm of the attacks is the ability to warn the patient to avoid all trigger factors, including any unnecessary strain, on the days before the predicted attack. Under treatment, the patients are better able to resist the factors of strain. In 1938 I was able to buy 25 mg. ampules of testosterone propionate in sesame oil. I then started treatment of male patients. I learned that the testosterone propionate alone would not control the severest headaches. After much experimentation, I found that by giving ½ ampule of estradiol benzoate U. S. P. to 2 ampules of testosterone propionate I achieved excellent results. In the first four weeks of treatment I give 20 to 30 ampules of testosterone and 5 to 8 ampules of estradiol benzoate. In general, the headache in the male yields more readily to treatment than that in the female. The seven day rhythm of the headache in males is not apparent except in the severest cases. Under treatment the bad headaches usually appear about every three months. Dr. Friedman indicates improvement in only 19 per cent of patients treated with estradiol benzoate. In view of my experience that inadequate dosage tends to increase the severity of the headaches, I should like to ask Dr. Friedman what dose he used and for what length of time.

DR. LEON UNGER, Chicago: As a result of long experience and testing, both clinically and by elimination diets, I believe that true migraine is an allergic entity. In the typical type of migraine, the patient is almost certainly allergic to some food or foods. If one can find the food or foods and if the patient will conscientiously avoid these foods, there almost certainly will be no further attacks of migraine, even though the psychological and the nervous factors persists. The problem is to find the food. The history may give a clue. Skin tests are of little value in the unilateral type of headache but help a great deal in those frontal headaches which are associated with nasal allergy. That type of headache I do not believe is true migraine. In our practice, we have relieved more than 25 patients in the last few years by having the patient avoid one food at a time. We give him a printed list, and he is instructed to omit, say, wheat and all foods which contain wheat; then eggs and all foods which contain egg, and so on. Then, about a week to 14 days later, the patient comes to the office in a fasting condition, and we deliberately feed him the particular food, in large quantities. We do not trust the patient to eat the food at home. For this feeding test we may give him two large glasses of milk, and, an hour later, two more glasses. Or we give him a bowl of cream of wheat, and, an hour later, another bowl, or four eggs, two and two. If the patient is allergic, he usually will have a typical migraine attack in one-half to 24 hours. Then our treatment is merely one of avoidance. The patient is told how to avoid the offending food completely and carefully; no other treatment is necessary. I have never been able to get the results with cafergot or the ergotamine injections which Dr. Friedman quotes here. When we find the cause and remove the food, the patient is cured, as long as he avoids it; in other words, he is just like an asthmatic person who is sensitive to dog hair or wheat or eggs or fish. Let him get the dog back, or eat the wheat, egg or fish, and his attacks will return.

DR. MORRIS J. TISSENBAUM, Brooklyn: I should like to speak from experience in a large neurologic and psychiatric clinic where we treat veterans with all kinds of headaches. Dr. Friedman emphasized the use of ergot alkaloids in combination with other drugs, and mentioned cafergot as being the most effective when taken by mouth. I should like to corroborate that statement, with reference not only to migraine but to other types of chronic headache. Dr. Friedman did not emphasize the method of medication. I have had patients who received cafergot from a private practitioner but who claimed it was ineffectual. I found they were taking cafergot, 1 tablet three times a day for weeks, with no results, of course. Cafergot should be given in a certain sequence, 1 or 2 tablets, perhaps 3 tablets, at the first sign that the headache is beginning; then, a half-hour later, another tablet; then, a half-hour later, another, and so on. Where no relief had been obtained in private practice with this method, not simply with migraine but also with other types of chronic headaches, we got good results in the clinic, and our figures are quite similar to those of Dr. Friedman. Psychotherapy has been rather ineffectual for my migraine patients. The only way in which I obtained relief for these patients is through sympathomimetic therapy, as in the use of gynergen® or cafergot. It is curious that often patients do not respond to cafergot but do respond to ergotamine tartrate or one of its derivatives, such as dihydroergotamine (DHE-45). Sometimes cafergot is difficult for these people to manage; they become rather sick. As to psychotherapy as a prophylactic measure for migraine, we had poor results; but, in the use of psychotherapy over a prolonged period for other types of chronic headaches of psychogenic nature, we had good results, with the help of various drugs, like cafergot and the combinations of the ergot derivatives and other drugs, such as bellafoline,* for symptomatic relief.

DR. FREDERICK STERN, New York: In our headache clinic at the New York regional office of the Veterans Administration we treated about 250 patients with different types of chronic headache. There were 50 cases of migraine in this group. We can corroborate the results of Dr. Friedman. I wish to stress the importance of careful history taking and examination of patients with various types of headaches to determine the exact indication for cafergot. We made a number of allergy studies, but we were not impressed with the findings.

DR. MILES ATKINSON, New York: I, an otolaryngologist, feel complimented by the invitation to discuss a paper presented by neurologists. I owe it, no doubt, to my proclaimed interest in migraine and other types of periodic headache, which are of such frequent occurrence in my specialty. Drs. Friedman and von Storch deserve the thanks of all of us for their carefully controlled study, in a large series of cases, of the value, or otherwise, of various types of advocated therapy. As they pointed out, the terms migraine and periodic headache are not

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synonymous. Classic migraine is a fairly clearcut clinical entity. To use the term "migrainous," for instance, for chronic headache of different pattern and undetermined cause is to becloud the issue, and often to lead to incorrect management and faulty conclusions. Otologists face a similar difficulty with Ménière's syndrome, cases of recurrent vertigo which do not present the classic triad of symptoms often being referred to as instances of pseudo-Ménière's syndrome. It has been my plea in regard to Ménière's syndrome, and it applies equally to the migraine syndrome, that until the basic etiological factor or factors have been determined, we should pay meticulous attention to diagnosis and nomenclature and should avoid names preceded by "pseudo," which of itself says the diagnosis is false, and adjectives ending in "-ous," which mean "I haven't the faintest idea what this really is, but it looks something like." Even if we agree that the mechanism of the attack is vascular, we are still at a loss as to the basic disturbance which renders the peripheral vascular system so responsive to a large variety of trigger factors, and its surrounding nerve plexus so sensitive to change in caliber as to cause pain. In short, we are as yet completely ignorant as to the basic cause of this syndrome. This problem will be solved in due course, and my expectation is that the answer will turn out to be on the basis of a metabolic disturbance. I cannot believe that personality traits, emotional upsets, allergy and the like are more than precipitating factors.

DR. ARNOLD P. FRIEDMAN, New York: Dr. Lippman and Dr. Unger stated that they obtained inadequate or ineffectual results with ergotamine in some cases. Our experience would essentially eliminate these cases as being those of migraine. However, the question of an endocrine disorder is always interesting. Our dose of estradiol benzoate was from 10,000 to 20,000 rat units a week, for several months. Testosterone in females was used up to about 200 mg. a month. We did not include the dosage in this discussion because of our time limit. The activity of the adrenal cortex during a migraine attack was of interest. We studied 15 patients prior to and during the headache attack. Much to our surprise, there was no change in the eosinophil count. Although this is a preliminary study, it seems to indicate there is not much activity in the adrenal cortex during the attacks of migraine. Dr. Unger mentioned the problem of allergy. In our experience, the results with desensitization tests, elimination diets and specific allergens, and even with the history of allergy, are not remarkable in patients with classic migraine. I could best conclude by stating that the object of migraine therapy, of necessity, is limited by present knowledge of the etiology and, since the prime cause is yet unknown, treatment consists largely of attempts to offset whatever known factors we have in abnormal physiology.

DR. J. C. VON STORCH, New York: Some years ago, in Boston, I evaluated 800 cases of migraine taken from the literature, and 600 cases of our own, in conjunction with Dr. Rackemann. It was our impression that allergy played no part in classic migraine. We also treated at that time some 300 patients with various estrogenic substances; at first, they all got better; later, they all got worse.

Diagnosis of Drug Allergy.—Because skin reactions are almost always negative in drug allergy, the physician may be handicapped in making the diagnosis. Nevertheless, the history is a more reliable guide in this type of allergy than in most others. The diagnosis depends in large part on a history of initial exposure to a drug and re-exposure with subsequent development of symptoms. Often a clue may be obtained from the nature of the reaction, particularly from the character of the lesion in cutaneous reactions. This is, of course, only a clue, because different drugs may cause similar lesions. A great deal of dependence is also placed on the effects of experimental exposure to the suspected drug. It must be emphasized, however, that in many instances, such as in sensitivity to cinchophen, aminopyrine, or aspirin, which may produce liver damage, granulocytopenia, or asthma, clinical tests may be very dangerous and ill advised. Samuel M. Feinberg, M.D., Allergy in Practice, ed. 2, The Year Book Publishers, 1946, p. 341.

PSEUDOCYESIS: A PSYCHOSOMATIC STUDY IN GYNECOLOGY

Paul H. Fried, M.D.
A. E. Rakoff, M.D.
R. R. Schopbach, M.D.
and
Albert J. Kaplan, M.D., Philadelphia

On the basis of clinical observations, psychic disturbances have been recognized as an etiological factor in some cases of menstrual dysfunction and female sterility, apparently acting through mediation of the endocrine system.[1] The lack of objective studies has led some to consider the need for more definite proof, especially in infertility cases.[2] Pseudocyesis, a condition in which a woman firmly believes herself to be pregnant and in which develop many of the symptoms and signs of pregnancy, however, lends itself well to an evaluation of the relation of the psyche to the female sex-endocrine mechanism. Although 465 case reports of pseudocyesis may be found in the literature, they have been recorded chiefly as medical curiosities, with but few observations or studies that might shed light on the modus operandi of this interesting psychosomatic disturbance.[3] The present report is an evaluation of the data obtained by gynecologic, endocrinologic and psychiatric surveys during, after and between episodes of the syndrome.

CASE MATERIAL

Few cases of pseudocyesis have been reported in the literature since 1900, as noted in Bivin and Klinger's summarization [3a] of the 444 cases recorded up to 1937, and there have been only 21 case reports [4] since then. It is probable, however, that the incidence has not decreased, since 22 of our 27 patients were admitted to the endocrine clinic at Jefferson Hospital from July 1946 to January 1949, giving a ratio of one studied case of pseudocyesis per 250 maternity clinic admissions. Our 27 patients, of whom 23 were Negro and four were

Dr. Schopbach is now at Clifton Springs Sanitarium, Clifton Springs, N. Y.

Olive John Morgan, Ph.D., Director of the Psychological Clinic, interpreted the Bellevue-Wechsler, Rorshach and Szondi tests.

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From the Division of Endocrine and Cancer Research, Department of Obstetrics and Gynecology and Department of Psychiatry, Jefferson Medical College and Hospital, Philadelphia.

1. These bibliographic references are omitted from THE JOURNAL because of lack of space and will appear in the authors' reprints.

2. Hanson, F. M., and Rock, J.: The Effect of Adoption on Fertility and Other Reproductive Organs, Am. J. Obst. & Gynec. **59**: 311, 1950.

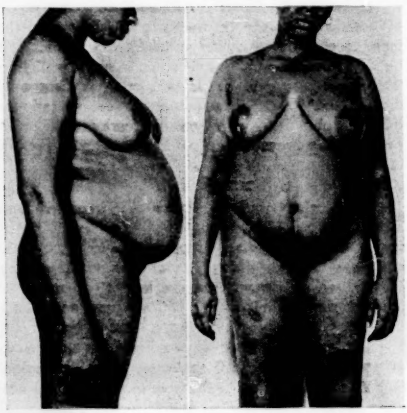
3. (*a*) Bivin, G. D., and Klinger, M. P.: Pseudocyesis, Bloomington, Indiana, The Principia Press, Inc., 1937. (*b*) Matthews, R. A., and O'Brien, W. R.: Psychosomatic Approach to Gynecologic Problems, M. Clin. North America **32**: 1583, 1948. (*c*) Moulton, R.: The Psychosomatic Implications of Pseudocyesis, Psychosom. Med. **4**: 376, 1942. (*d*) Rutherford, R. N.: Pseudocyesis, New England J. Med. **224**:639, 1941. (*e*) Steinberg, A.; Pastor, N.; Winheld, E. B.; Segal, H. I.; Shechter, F. R., and Colton, N. H.: Psychoendocrine Relationships in Pseudocyesis, Psychosom. Med. **4**: 376, 1942. (*f*) Daley, M. D.: Pseudocyesis, Post-Grad. M. J. **22**: 395, 1946. (*g*) Ramos, A. P.: Endocrine Aspects of Pseudopregnancy in Woman, Dia méd. **14**: 842, 1942. (*h*) Ramos, A. P.: Endocrine Aspect of Pseudopregnancy in Humans, Biol. Inst. de Matern. **11**: 137, 1942. (*i*) Straetmans and Geeaert: Pseudo-gravidité par kyste lutéinique de l'ovaire, Bruxelles-méd. **26**: 277, 1946. (*j*) van Tongeren, F. C.: Pseudogravidité par les kystes lutéiniques, Gynéc. et obst. **34**: 350, 1936. (*k*) Goldberg, A. T., and Schatz, M. M.: Pseudocyesis, California & West. Med. **53**: 270, 1940.

4. Footnotes 3 *b* to 3 *k*.

white, constitute the largest single group thus far reported. Their ages were 18 to 36 years, with the majority in the middle twenties. Eleven of the women had never been pregnant. All of our patients were clinic patients, but it should be noted that Bivin and Klinger [3a] found a wide range in social and economic status. Relative to pseudocyesis our patients were observed for one to three and a half years, during which 36 episodes of the syndrome were recorded. The number of episodes per patient was one to four. The duration, which varied from four to 14 months, extended beyond nine months in six cases. The patients firmly believed themselves to be pregnant and did not have consciously simulated or true hallucinatory pregnancies, unconscious pregnancy phantasies, pregnancies represented by tumors with endocrinologic changes or missed abortions.

THE CLINICAL SYNDROME

The patients presented themselves with the common symptoms and signs of pregnancy (figure). The initial and commonest symptom was a menstrual disturbance,



Patient with pseudocyesis showing typical "pregnancy" changes.

which was present in 26 of the 27 patients, all of whom previously had fairly normal menstrual histories. Nineteen had hypomenorrhea, and seven were amenorrheic. Twenty-four patients noted a gradual abdominal enlargement, the growth rate of which approximated that of normal pregnancy. The other abdominal observations were not like those of normal pregnancy, namely, the inverted umbilicus, the uniform, rounded distension and the rubbery, tense tone. Breast changes were equally frequent and consisted of enlargement, tenderness, secretion of milky or cloudy fluid, venous engorgement, enlarged Montgomery's tubercles and enlargement plus darkening of the areola. The fluid has the characteristics of colostrum or milk.[3c] It is notable that among the 22 patients with breast secretions there were 10 nulligravidas, of whom seven had primary and secondary areolas.

Fetal movements were reported by 22 patients, but these frequently differed from those of normal pregnancy in the time of appearance, vigor, type and location. In only five cases did they appear during the fourth or fifth months, while in the others they were felt initially as early as the first month or as late as the eighth month. The quivering and pulsating sensations were usually noted in the left upper quadrant of the abdomen. Fetal heart sounds were reported as being heard in two patients while in "labor" in the maternity ward. "Labor," which had occurred at the "expected date," ceased abruptly when the patients were told that they were not pregnant.

A softened cervix was present in 19 patients, and in 11 of these an enlargement of the uterus was recorded as well. The examining physicians reported eight uteri to be the size of six to 12 week pregnancies, and three to be the size of five, six and eight month pregnancies, which coincided with the estimated period of gestation. Repeated pelvic examinations made by us with deliberate care to obtain relaxation of the tense abdominal musculature revealed that the uteri were never enlarged to more than the size of approximately a six weeks' gestation. Moreover, in no case were the uterine or cervical changes entirely typical of any stage of pregnancy.

Weight gains usually were greater than in normal pregnancy. At three to four months, eight patients had gained between 25 and 50 pounds (11.3 and 22.7 Kg.). Twelve patients admitted increased appetites. Perverted appetites were present in four women, one of whom insisted on a mixture of crabmeat and ice cream. Other symptoms of pregnancy, such as nausea, urinary frequency, salivation, sleepiness and faintness, were also present in many instances.

As diagnostic aids, biologic pregnancy tests and roentgenograms of the abdomen were made in some cases. The rat ovary hyperemia and Friedman pregnancy tests were done in 19 cases. Results of tests were positive in four cases (three Friedman and one rat ovary hyperemia), which proved negative on being repeated. In these four patients, who considered themselves to be four to seven months pregnant, pelvic examinations were entirely normal. Of the 16 patients who had roentgenograms, questionable soft tissue masses the size of three months' pregnancies were reported in three women. Pelvic examinations and reevaluations of the roentgenograms showed no abnormalities.

Diagnosis.—In view of these observations one may readily understand DeLee's statement [5] that pseudocyesis may tax the diagnostic abilities of the ablest obstetrician. This had been borne out by Bivin and Klinger's report that one or more physicians maintained the diagnosis of pregnancy in 161 of 444 cases of false pregnancy.[3a] In our series, nine of the 27 patients were told that they were pregnant by 16 of 40 examining physicians, and each of the other patients "appeared" to be pregnant to at least one physician. One patient (figure) was considered to be pregnant by four physicians. This is indicative of the ease with which these patients passed superficial examinations as being pregnant and thus were carried along for months before the true diagnosis was made. The diagnoses of pregnancy added psychic trauma in all cases, convinced three uncertain patients that they were pregnant, had varied

5. DeLee, J. B.: The Principles and Practice of Obstetrics, ed. 7, Philadelphia, W. B. Saunders Company, 1938, p. 270.

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social effects and caused medicolegal problems relative to sickness insurance and maternity benefits. One patient claimed that an abortion had been performed by the physician after his therapy had been followed by menses and disappearance of the syndrome.

The majority of errors in diagnosis were in the early months and were due to a failure on the part of the physician to examine the patient with sufficient completeness, to evaluate the findings and especially to consider the possibility of pseudocyesis. The patients were referred eventually to the endocrine clinic with the diagnosis of a menstrual disturbance or a threatened miscarriage. The frequently noted histories of miscarriages led physicians to delay pelvic examinations in two cases and to offer a presumptive diagnosis of threatened abortion. Pseudocyesis patients have been operated on for supposed ectopic pregnancies and for pregnancies thought to be complicated by placenta previa.[3a]

ETIOLOGY

The etiological agents primarily considered have been psychic or endocrine disturbances. The psychogenic factors associated with pseudocyesis have been an intense desire for or a great fear of pregnancy.[6] In our group all but one of the patients were childless and the wish factor was predominant during the gynecologic survey. All were married, and each spoke of her and her husband's strong desire for a child. Although 16 had pregnancies previous to pseudocyesis and three had delivered live babies in the past, only one had a living child. Moreover, 24 patients had tried to conceive without success for two to 17 years and can be regarded as sterility problems. Three other couples had made definite premarital plans for early pregnancy, since the men were elderly and were anxious to have children. Menstrual disturbances occurred initially with the first expected menses after these marriages and were followed by pseudocyesis, which fulfilled the patients' desires to please their husbands. Psychiatric survey revealed that in others the syndrome frequently followed a situational stress that the patient believed could be helped by a pregnancy.

In many cases the "pregnancies" were motivated subconsciously so that the patient might (1) secure the husband's wavering affections and bolster a faltering marriage, (2) prove the ability to conceive and to become a complete woman, (3) achieve parity with other women, especially close friends, (4) obtain a child as a plaything and companion and (5) effect self punishment. The patients were found to be gullible, to have intelligence levels that ranged from superior to moron, to be prone to accept folklore and to have aberrant sex histories and predisposing basic personality defects. The psychiatric studies also revealed low frustration tolerance, pronounced insecurity, difficulty in interpersonal relations, an inability to resolve tensions and a distaste for pregnancy. The basic pychological mechanism appeared to be a conversion of anxiety arising from the conflict between (1) innate sexual drives plus the stress of present life situations in favor of pregnancy and (2) folklore, early teachings and experiences that had negatively conditioned them in regard to reproduction.

Of the various endocrine disturbances that have been reported as etiological factors, evidence has been presented only for the persistent corpus luteum or corpus luteum cyst theory.[7] This has been based on two observations: the presence of a persistent corpus luteum in the rat and rabbit during pseudo pregnancy and the finding of a corpus luteum cyst or a persistent corpus luteum in women at the time of operation for supposed ectopic pregnancies or tumors complicating "pregnancy."[8] Van Tongeren, in a review of such cases, stated that in addition to the corpus luteum factor there probably was an associated special cause for pseudocyesis.[3j] In our series, enlargement of the ovary was present in eight patients, of whom four had past histories of pelvic inflammatory disease and previous findings of cystic adnexal masses. Although one of these four patients was "cured" of the pseudocyesis syndrome, the adnexal mass persisted throughout an eight month follow-up period.

The importance of the psychic factor was notable when a persistent corpus luteum and the associated symptoms were evoked with chorionic and lactogenic gonadotropins in a sterility patient who greatly desired a child. Although the woman considered herself to be pregnant, pseudocyesis did not appear, we believe, because she did not have the psychic disturbances noted in the pseudocyesis patients.

In this series it was evident from the previously noted data and success of superficial psychotherapy that the etiological agent was a psychogenic factor and that pseudocyesis was more closely related to conversion reactions and hysteria phenomena than to the deeper, more persistent types of psychosomatic disturbances.

Laboratory Studies.—Hormonal studies were done during and after episodes of the syndrome to determine the relative state of function of the sex-endocrine system. Ovarian function was studied by endometrial biopsy (taken premenstrually in patients with cycles), urinary estrogen (castrate mouse vaginal smear method) and pregnandiol assays (Venning and Browne method[9]) and vaginal smears. The gonadotropin function of the pituitary was investigated by urine gonadotropin assays for the follicle-stimulating hormone (mouse uterine weight method) and in a few cases by urine lactogenic hormone assays (local pigeon crop method[10]) as a measure of luteotropic activity. 17-Ketosteroid determinations were also done. The patients with hypomenorrhea collected urine specimens for estrogen and pituitary gonadotropin assays at approximately midcycle, when the output of these hormones is normally at a peak. Two to 10 assays were done in each patient so evaluated. The follicle-stimulating gonadotropin titers were low normal in two and diminished in 24 patients. The estrogen levels were elevated in nine, normal in 11 and diminished in three patients. The vaginal smears were corroborative of the urinary estrogen titers. Weekly urinary assays and vaginal smears in three patients demonstrated persistently high estrogen and low gonadotropin levels.

6. Footnotes 1 *a*, *b* and *i*; 3 *a* to 3 *f*.
7. Footnotes 3 *a*, *b* and *c*; 3 *g* to 3 *k*.
8. Moulton,[8c] van Tongeren.[3j]
9. Venning, E. M., and Browne, J. S. L.: Isolation of Water-Soluble Pregnandiol Complex From Human Pregnancy Urine, Proc. Soc. Exper. Biol. & Med. 34: 792, 1936.
10. This test was done through the courtesy of R. W. Bates, Squibb Institute.

For evaluation of progesterone production, 12 endometrial specimens were obtained in 11 patients by endometrial biopsy (table). In only two cases was there an absence of any secretory activity. A normal premenstrual endometrium was present in two patients. In the other eight instances, early or midsecretory phases or the mixed types of endometria were present. In each instance there were associated diminished gonadotropin and normal or elevated estrogen titers.

Pregnandiol was measured in the urine in only one case and was found to be present in a concentration of 5.0 mg. per 24 hours. Lactogenic hormone was present in the urine of five studied patients in the following amounts: 34, 6, 2.5, 1.0 and 0.2 I. U. per 24 hours. Although normal values for luteotropin have not yet been fully established, preliminary studies indicate that in two cases the titers were within normal limits for the luteal phase, while the presence of small amounts in the other three may be of some significance. With single exceptions these patients also had high estrogen titers, endometria with secretory activity and milky breast secretions. An outpouring of lactogenic hormone all instances there was evidence of progesterone activity, the probability of persistence of corpus luteum function suggested itself. This could account for many of the clinical manifestations, such as the menstrual disturbances, the enlargement and tenderness of the breasts, darkening of the areola, softening of the cervix and enlargement of the uterus. If in addition it was presumed that lutein function persisted because of continued stimulation by the luteotropic hormone of the anterior pituitary, one could also explain the breast secretion and low or absent follicle-stimulating hormone values that were found so consistently, but which are not in agreement with high titers reported in single assays in each of three cases by Steinberg and his group [3e] and in one case by Moulton.[3c]

Few assays for luteotropin [12] have been done in the human, but as already indicated, there was activity in all five cases assayed, and in two of the cases the amounts appear to be sufficient to cause persistence of lutein function. It may be that this hormone is produced in an irregular fashion, so that repeated assays in the other cases may reveal large amounts at intervals. In

Endometrium and Hormone Assays

Patient	Menses	Interval Since Last Menstrual Period	Endometrium	Endometrial Glycogen	Urine Gonadotropins	Urine Estrogens
A. M.	Oligomenorrhea and hypomenorrhea	4th week	Late secretory	+	Diminished	Normal
R. M.	Oligomenorrhea and hypomenorrhea	4th week	Late secretory	+	Diminished	High
L. G.	Oligomenorrhea and hypomenorrhea	8th week	Early secretory	+	Diminished	High
A. McL.	Oligomenorrhea and hypomenorrhea	4th week	Early secretory	+	Diminished	High
A. R.	Oligomenorrhea and hypomenorrhea	4th week	Mixed secretory	±	Diminished	Normal
R. M.	Oligomenorrhea and hypomenorrhea	3rd week	Mixed secretory	±	Diminished	High
D. D.	Oligomenorrhea and hypomenorrhea	4th week	Mixed secretory	+	Diminished	Not done Normal smear
M. G.	Amenorrhea	11 months	Mixed secretory	±	Diminished	Normal
W. M. M.	Amenorrhea	8th week	Hyperplasia Mixed secretory	±	Diminished	Normal
P. D.	Oligomenorrhea and hypomenorrhea	4 months	Cystic hyperplasia	0	Diminished	High
E. H.	Oligomenorrhea and hypomenorrhea	3rd week	Late proliferative	0	Diminished	High

offers an explanation for the false positive results of pregnancy tests since it has been demonstrated that lactogenic hormone will evoke positive rat ovary hyperemia reactions.[11]

The urinary 17-ketosteroid titers in six patients and results of two hour glucose tolerance tests in 13 patients were normal. Liver function studies, which included cephalin flocculation, thymol turbidity, sulfobromophthalein and urobilinogen, were done in 14 patients and were normal. Although no patient had clinical symptoms or signs of thyroid dysfunction, basal metabolic and serum cholesterol evaluations were done in 13 cases and were normal. Skull roentgenograms, which were done in eight patients for possible pituitary changes, were normal. After effective therapy the endometrial tissues and the cyclic urinary gonadotropin and estrogen titers were normal in three patients so evaluated during a three month period.

MECHANISM OF ACTION

It became evident early in our study that good ovarian function was present in these cases, as indicated by the vaginal smears, the estrogen assays and the endometrial biopsy specimens, and that the amenorrhea or hypomenorrhea that these patients exhibited was of the "hyperhormonal" type. When it was found that in almost view of the pelvic observations it is likely that persistence of lutein function in most of these cases was not due to cyst formation, but to persistence of a corpus luteum or diffuse luteinization of the ovaries. This is known to occur in some animals and shown to be present in the human under some circumstances.[13]

To complete the picture one must assume that the psychic factor, namely, a conflict that appears best solved by conversion into "pregnancy," is capable of affecting the pituitary, possibly by way of the hypothalamus,[14] causing the release of lactogenic hormone,

11. Fried, P. H.: Factors Influencing the Rat Ovary Hyperemia Reaction as a Test for Pregnancy, Am. J. Obst. & Gynec. 57: 868, 1949.

12. Coppedge, R. L., and Segaloff, A.: A Method for the Assay of Prolactin in Human Urine, read before the Association for the Study of Internal Secretions, June 3, 1949.

13. Papanicolaou, G. N.; Traut, H. F., and Marchetti, A. A.: The Epithelia of Woman's Reproductive Organs, New York, Commonwealth Fund, 1948, pp. 14-19.

14. Theobald, G. W.: Centers in the Hypothalamus Controlling Menstruation, Ovulation, Pregnancy, and Parturition, Brit. M. J. 1: 1038, 1936. Footnotes 1d' to 1f'. Sayers, G., and Sayers, M. A.: The Pituitary-Adrenal System, in Recent Progress in Hormone Research, edited by G. Pincus, New York, Academic Press, Inc., 1948, vol. 2, pp. 81-116. Markee, J. E.; Sawyer, C. H., and Hollinshead, W. H.: Adrenergic Control of the Release of Luteinizing Hormone from the Hypophysis of the Rabbit, in Recent Progress in Hormone Research, edited by G. Pincus, New York, Academic Press, Inc., 1948, vol. 2, pp. 117-132. Everett, J. W.: Pituitary-Ovarian Relationships, in Progress in Clinical Endocrinology, edited by S. Soskin, New York, Grune & Stratton, Inc., 1950, pp. 319-326.

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the suppression of follicle-stimulating hormone and consequent persistence of lutein function with the production of estrogen and progesterone. The initial menstrual disturbance gives the psyche a reality factor on which "pregnancy" can be further developed through subconscious simulation of the symptoms of pregnancy. The abdominal enlargement is due to fat accumulation and the forced contraction of the anterior abdominal musculature. During pelvic examinations, as the patients were made to relax, the enlarged abdomens flattened completely but reverted to the former protuberant state after the completion of the examination. Intestinal movements probably explain the sensations of "fetal movement."

Psychic disturbances have long been suspected as an initiating factor in certain cases of menstrual disorders and ovarian dysfunctions. Several patterns of hormonal dysfunction have been noted in such cases. In the syndrome termed "hypothalamic" amenorrhea, hormonal studies by Klinefelter and associates [14] and by Reifenstein [14b] indicate a lack of estrogen in the presence of normal levels of follicle-stimulating hormone, probably caused by a lack of luteinizing hormone due to an interference in the hypothalamic mechanism that regulates its release. Rakoff has found two additional hormone patterns in patients with psychogenic amenorrhea: (1) absence of estrogen due to a lack of follicle-stimulating hormone, apparently due to pituitary inhibition, (2) lack of estrogen associated with high titers of follicle-stimulating hormone, apparently due to primary inhibition of ovarian function and generally accompanied by menopausal symptoms. The hormonal mechanism that we have found in pseudocyesis is in pronounced contrast to other types of "psychogenic" amenorrhea in that it represents a state of ovarian hyperfunction probably mediated through a hypothalamic disturbance in the regulation of the gonadotropic hormones.

TREATMENT

Many therapeutic agents have been used, but too often the results have been based on the immediate effect.[15] In this series, therapy was considered effective only after a full loss of the syndrome and absence of recurrence during a follow-up period of six or more months. After termination of the episodes, 20 patients were observed for six months to three years. Whenever possible the following treatments were used: first the patient was informed of the true diagnosis; next, she was given a psychiatric interview, then psychotherapy and, finally, endocrine therapy. Of 27 patients who were informed of the true diagnosis, there was "acceptance" by 13, followed by a loss of symptoms, but recurrence of the syndrome followed within a few months. Preliminary psychiatric interview of 10 patients was without effect. Psychotherapy, used in 13 cases, was curative in six, was effective in five when combined with testosterone propionate or curettage and indeterminate in two patients, who failed to return.

Three patients were relieved of the syndrome after endometrial curettage, which followed psychotherapy. Curettage, which was done during the period of study, had been ineffective. Five patients, all of whom had high urinary estrogen titers, were treated with hormonal substances. They initially received one to three courses of progesterone by injection in doses of 25 to 100 mg. daily for three days without effect. Four of the patients were then given daily injections of 50 mg. of testosterone propionate for three days.[15a] In each case the injections were followed within a few days by the onset of menses and then the loss of the syndrome. The two patients in this group who in addition had received psychotherapy remained well, while the other two patients had immediate recurrences. In four cases desiccated thyroid had been given previously in daily doses of 1½ to 3 grains (0.10 to 0.20 Gm.) without response.

Providing information, that is, bluntly telling the patient that she is not pregnant, which has been the usual therapeutic procedure in such cases, is to be condemned. In this series it was of no therapeutic value, since the conflict factor remained uncomprehended and unaltered. In addition, it was an embarrassing blow, caused confusion and in some cases created hostility. After being informed of the true diagnosis, one patient determinedly threatened suicide. Some patients trailed off to other physicians seeking a diagnosis of pregnancy, while others, without conviction, responded with a loss of symptoms alone, which was followed by an early repetition of the syndrome. On the other hand, psychotherapy provided the patients with support and with insight into the condition and produced in most instances a complete reversal of the process without recurrences. After psychotherapy one patient was followed in a cured state for three years, which was in contrast to the short lasting "cure" by information during each of the three episodes in the previous three years. The value of psychotherapy was also evidenced in another patient in whom, after cure by psychotherapy, a recurrence of syndrome failed to develop one year later despite a repetition of the trigger symptom, a menstrual disturbance. Patients who gained only a limited insight into the condition and their problems required adjunctive therapy, such as testosterone propionate or curettage. The testosterone evoked menstrual bleeding and then a loss of the syndrome probably by causing a depression of the estrogen effect. The appearance of normal menses was final proof, since aberrations of menses to these patients were synonymous with pregnancy. Curettage may have been a final convincing measure by proving that their uteri were empty.

Therapy was not directed at revamping ingrained personality factors but toward making the patient recognize the conversion mechanism and better resolve the factors producing the anxiety. The short term psychotherapy consisted of rapport, discussion, interpretation, reassurance and support. After effective therapy, the loss of symptoms and signs followed a similar course in most patients. The onset of normal menses appeared in one to three days, with an immediate loss of symp-

15. Footnotes 3 *c* to 3 *k*.

15a. The hormones were supplied by the Schering Corporation, Bloomfield, N. J.

toms and a gradual loss of signs. The breast signs were the last to disappear, lasting usually about three weeks. Normal cyclic hormonal patterns were noted as well.

SUMMARY

A psychic disturbance was demonstrated by clinical, endocrine and psychiatric surveys to be the etiological factor in 27 cases of pseudocyesis. The symptoms and signs, which were sufficient to convince 16 of the 40 examining physicians that nine of the patients were pregnant, were due to an intense conscious desire for children in these women, of whom 24 were sterility cases. Psychiatric survey revealed that the basic mechanism appeared to be a conversion of anxiety arising from conflict between (1) strong maternal drives plus the stress of present life situations in favor of pregnancy and (2) folklore, early teachings and experiences, which had negatively conditioned the patient in regard to reproduction. In some cases the syndrome was the patient's answer to a situational stress that could be relieved by pregnancy. Directly evoked by the psyche were such symptoms as morning nausea, fetal movement and progressive abdominal enlargement. "Pregnancy" signs were produced indirectly through the endocrine system and consisted of amenorrhea or hypomenorrhea, uterine enlargement, cervical softening and breast changes, such as enlargement, tenderness, secretions of milky or cloudy fluid, venous engorgement and enlargement plus darkening of the areola.

By means of hormonal assays, vaginal smears and endometrial biopsies, it was possible to establish the following hormonal pattern as the basis for the mechanism of pseudocyesis.[16] These women apparently had persistent luteinization of the ovaries as indicated by (1) varying degrees of secretory (progesteronic) activity in the endometrium, (2) the presence of normal estrogen levels in the urine and (3) good estrogen effects on smears. This luteinization effect appears to be the result of ovarian stimulation by the pituitary lactogenic (luteotropic) hormone, as indicated by its presence in the urine of five patients tested. It is likely that the psychic factors acted on the endocrine system by utilization of pathways from the cortex through the hypothalamus to the anterior pituitary gland causing release of the luteotropin and suppression of the follicle-stimulating hormone.

In most cases, superficial psychotherapy produced a complete reversal of the process without recurrence. Those patients who had limited insight after psychotherapy required direct evidence, such as the onset of menses or the demonstration of empty uteri to finally convince them. This was provided by the adjunctive use of endocrine therapy or uterine curettage. Effective therapy was followed by the dissipation of the pseudocyesis syndrome, by a return of normal cyclic menses and hormonal patterns and by pregnancy in four of the eight infertile nulligravidas.

1812 Spruce Street, Philadelphia.

16. Rakoff, A. E., and Fried, P. H.: The Hormonal Pattern in Pseudocyesis, read before the Association for the Study of Internal Secretions, June 4, 1949.

ABSTRACT OF DISCUSSION

DR. DAVID A. BOYD, Rochester, Minn.: These patients clearly demonstrate the reaction of the human organism to powerful personality needs and instinctual drives. The female reproductive organs are much influenced by psychological stimuli, and conversely the emotional pattern is periodically modified by the hormonal tides. Pseudocyesis represents a *forme fruste* of pregnancy, in which emotional attitudes of pregnancy are present and an aberrant, abortive hormonal response occurs under the impact of powerful psychogenic stimuli when the patient believes that she is pregnant. The latter are well shown by the reported instances of hypomenorrhea, amenorrhea, changes in the cervix and breasts, probable enlargement of the uterus and weight gain. This reaction pattern probably represents a hysterical conversion type of response, but unlike most conversion reactions, it involves the hormonal-metabolic systems and autonomic nervous system patterns of reactions. This would indicate that the obvious symptoms should be stripped away and the nature of the disorder exposed to the patient's insight only with great caution and care. Disproving of the possibility of pregnancy by uterine curettage is an even more dangerous procedure, both from the psychological and medicolegal aspect. This procedure is highly traumatic and psychologically represents at least an induced abortion to the patient and may be the beginning of definite distortions and paranoid delusions that she has been surgically deprived of the products of conception. The therapy of these patients can be approached only from the standpoint that the patient has developed these symptoms because she needs them, and any treatment must be directed toward the total needs of the patient rather than the relief of the presenting symptom.

DR. IRVING F. STEIN SR., Chicago: The essayists have presented a most interesting and unique study of pseudocyesis. The condition is of medical interest because patients may present all the usual presumptive symptoms of pregnancy and may believe they experience fetal movements, contractions and even strong labor pains. Rather convincing evidence of progressive pregnancy, with abdominal enlargement, alteration in posture and gait and enlargement of the breasts with pigmentary and secretory changes, is often present. The course of the supposed pregnancy usually lasts nine to 10 months, but cases have been reported lasting from one to two years and four cases from four to 18 years. Recurrences have been noted. The youngest patient reported was 7 years of age; her symptoms lasted for seven months. The patient may be convinced of her condition not only because of her symptoms, her ardent desire for offspring or, as in some instances, by her fear of pregnancy, but also by the acceptance of her story by the physician who concurs in the diagnosis of pregnancy—either through incomplete examination or misinterpretation of his findings. The physical changes, usually due to fat accumulation and flatulency, are often puzzling. In order to make a definite diagnosis of pregnancy and to avoid deception in any case, the physician must ultimately rely on the positive signs of pregnancy. The use of x-ray is of both positive and negative value, especially in the last trimester of pregnancy. An x-ray film, even from three and one-half to four months on to term, should reveal fetal bony skeleton. This is a positive sign of pregnancy. The absence of fetal bones in suspected pregnancy and the failure to definitely elicit other positive signs should indicate the need for further inquiry. Here again, examination under anesthesia may be revealing, and if a small uterus is palpated, hysterosalpingography may be used to reveal a nonpregnant, normal uterine cavity. Hysterosalpingography is of more value than curettage, for the patient may accuse the physician of depriving her of the pregnancy by the operation of abortion. Pneumoperitoneum may also be used for corroborative evidence, by recording of normal pelvic organs on the films.

DR. PAUL H. FRIED, Philadelphia: X-ray studies, as diagnostic aids, were of no avail initially, since these patients were anxious to determine pregnancy and visited the physicians shortly after the onset of symptoms. Roentgenograms were helpful months later, however, as the attending physicians became suspicious of the pregnancy. It is likely that the diagnosis of

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pseudocyesis would have been made more often had the syndrome merely been considered. Pseudocyesis, unfortunately, has been included, in recent years especially, in the group of rare and therefore infrequently considered syndromes. It is hoped that this study will stimulate deliberation during the examination of certain types of patients, speculation relative to the diagnosis of pseudocyesis and increased consideration of the psyche as a cause of sterility and menstrual disturbances.

PORTACAVAL SHUNT FOR PORTAL HYPERTENSION

FOLLOW-UP RESULTS IN CASES OF CIRRHOSIS OF THE LIVER

Arthur H. Blakemore, M.D., New York

The problem of preventing death from the direct or indirect effects of gastrointestinal hemorrhage in cases of portal hypertension has taxed the wits of the medical profession over the years. That esophageal varices, the result of collateral blood flow via the coronary-esophageal vein circuit, constitute the danger site is common knowledge.

Progress has been made in the emergency handling of hematemesis, the result of bleeding from esophageal varices. Prompt transfusion and the establishment of esophageal tamponage are the surest ways of saving a life in this emergency. A satisfactory method [1] of balloon tamponage which is well tolerated by the average patient has been achieved. The esophageal baloon-nasogastric tube assembly may be procured from the Davol Rubber Company, Providence, R. I.

Emergency measures notwithstanding, patients with portal hypertension live under a constant threat of death. Patek,[2] in reviewing 124 patients with Laennec's cirrhosis who had received the modern medical treatment under especially favorable conditions, noted an incidence of hematemesis of 34 per cent. Furthermore, he observed that a patient who had suffered one hematemesis had but a 50 per cent chance of being alive one year thereafter.

The syndrome of portal hypertension, the result of portal bed block, is now generally recognized, namely, splenomegaly, secondary anemia, leukopenia and thrombocytopenia, a history of gastrointestinal bleeding and/or the presence of demonstrable esophageal varices. The site of portal block is assumed to be intrahepatic or extrahepatic in accordance with the presence or absence of evidence of disease of the liver. Whether the portal block be in the liver and due to cirrhosis or extrahepatic (29 per cent of the cases in the present series), chronic portal hypertension with congestive splenomegaly results.

Surgical measures that have been proposed and carried out for attempted control of portal hypertension may be classified under three groups in acccordance with their aims as follows:

Group I consists of measures calculated to promote the development of additional collateral veins, e. g., the Talma-Morison omentopexy and gauze packing about the esophagus through a mediastinotomy, as recently recommended by Som and Garlock.[3] The poor results from omentopexy are now known to all. Esophageal packing, carried out according to the technic recommended by Som and Garlock, has failed to prevent the recurrence of hemorrhage from esophageal varices in the 8 patients on whom my colleagues and I have operated. All 8 patients have been followed in excess of one year since operation.

Group II consists of measures to reduce the volume of portal blood and blood flow through the coronary-esophageal collateral veins, such as ligation of the splenic and short gastric arteries with splenectomy, suggested by Banti in 1894, and ligation of the left gastric and the right and left gastroepiploic arteries, advocated by Flerow in 1926.[4] To splenectomy with multiple arterial ligations have been added ligation and excision of branches of the coronary vein and excision of the periesophageal veins. Finally, recognizing the ultimate futility of attempts at devascularization, Wangensteen [5] in 1945 was the first to suggest ablation of the coronary-esophageal circuit by gastrectomy. This approach was carried one step further in 1947 by Phemister and Humphreys,[6] who advocated gastrectomy with gastro-esophageal resection.

Group III consists of operations to effect an immediate and substantial lowering of the portal pressure by anastomosis of the portal vein, or one of its large radicals, to the vena cava or the renal vein. Such anastomoses afford a low resistance circuit for a large volume of the portal blood to pass directly from the high pressure portal system into the relatively low pressure caval system. The term "portacaval shunt" has been employed by us to include any type of anastomosis that joins the portal and caval systems of veins.

Believing that advances in surgery, anesthesia and postoperative management would have a bearing on the clinical success of portacaval shunts, Dr. Allen Whipple and I undertook a restudy of the subject in the early 1940's.[7]

From the Department of Surgery, Presbyterian Hospital.

Read before the Section on Surgery, General and Abdominal, at the Ninety-Ninth Annual Session of the American Medical Association, San Francisco, June 28, 1950.

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3. Som, M. L., and Garlock, J. H.: New Approach to the Treatment of Esophageal Varices, J. A. M. A. **135**: 628 (Nov. 8) 1947.

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PRESENT STUDY

As of May 1950, the shunting operation has been accomplished in a series of 111 cases, with an over-all operative mortality of 16.2 per cent. Some early impressions have been confirmed, as follows:

1. Portacaval shunts employing either the portal or the splenic vein, when successfully achieved, are highly efficient in the prevention of gastrointestinal hemorrhage in cases of portal hypertension. A demonstrable reduction in the size of the esophageal varices following operation is the rule, and in many cases the varices disappear entirely. Confirmation of the effect of shunts in lowering portal blood pressure has been obtained at the operating table.

TABLE 1.—*Cause of Death in Patients Who Died Postoperatively*

Cardiac	8
Shock (hemorrhage)	5
Hepatic coma and renal failure	4
Mesenteric thrombosis	2
Hematemesis	2
	16

2. It is important to conserve the splenic vein for shunting purposes in cases of extrahepatic portal block. In our series of 111 cases of portal hypertension there were 32 patients (29 per cent) with normal livers in which the site of portal block was extrahepatic. The splenic vein had been rendered unfit for shunting purposes in nine of the 32 cases (29 per cent) because of a previous splenectomy. As is almost invariably the case, the portal vein was the site of block and therefore unusable; this committed us to the use of lesser veins (mesenterics) for shunting purposes in the nine cases. Splenectomy does not cure portal hypertension, and the surgeon should not attempt it unless he is prepared at the time to proceed with a splenorenal shunt.

3. There is a variability of operative risk in accordance with the normalcy of the liver. As would be expected, patients with portal hypertension who have normal livers in which the site of portal block is extrahepatic are excellent risks. For example, in the 32 cases belonging to this group there were but two postoperative deaths (6.9 per cent).

Early in our experience we began to appreciate the fact that with careful attention to improvement in preoperative preparation and postoperative handling the average patient with cirrhosis could be successfully operated on with reasonable risk. In order to broaden the base of acceptance of cirrhosis cases, over the years the concentration of effort to improve surgical management has gone on *para passu* with operations on patients having more severely damaged livers. The program of broadening the usefulness of the shunting operation for cirrhosis of the liver has not been achieved without additional risk. There were 16 postoperative deaths in the 79 cirrhosis cases (20.2 per cent).

TABLE 2.—*Predominant Etiologic Factor in 79 Cases of Cirrhosis of the Liver*

Hepatitis	33
Alcohol	11
Various hepatotoxic agents	6
Schistosomiasis	2
Uncertain	16
Common duct obstruction	5
Syphilis (treated)	6
	79

Table 1 outlines the causes of death as near as could be ascertained. Necropsies were obtained in nine of the 16 cases. We realize that in terms of present knowledge some of these deaths might have been avoided. One cardiac death was due to coronary occlusion. There was regret that the other two patients did not receive preoperative digitalization.

Real progress has been made in the prevention of operative shock by (1) being sure, on the basis of blood volume determinations before operation, that the patient's plasma and red blood cell volume have been brought up to normal (in our experience this measure alone has resulted in the use of 50 per cent less blood during the average operation), (2) detecting early the approach of shock by continuous arterial blood pressure readings, (3) keeping blood loss to the minimum during operation without regard to the time consumed.

TABLE 3.—*Major Indication for Portacaval Shunt in Cirrhosis of Liver*

	Period Elapsed from Time First Symptom Was Noted Until Operation Was Performed, Yr.										
	1/12	3/12	6/12	1	2	3	4	5	6	7	8	Total
Hematemesis or melena	8	8	10	16	11	3	..	1	3	..	1	61
Ascites	..	1	2	3	2	1	..	..	..	..	..	9
Various symptoms in cirrhosis and esophageal varices	..	..	..	3	3	2	..	1	..	..	..	9
												79

TABLE 4.—*Cirrhosis of the Liver*

	Operated on	Died Postoperatively	Died During Follow-Up	Living (5/31/1950)
Males	48	9	8	26
Females	36	7	4	25
Total	79	16	12	51

The above measures apply equally well to the prevention of hepatic coma and renal failure postoperatively. In addition, the patient with a severely damaged liver must be carefully prepared preoperatively in regard to increased proteins, carbohydrate intake and sodium removal; postoperatively, there must be prevention of abdominal distention and maintenance of protein and carbohydrate balance.

We do not believe the danger of postoperative mesenteric thrombosis to be great. There was adequate local cause for it in the two cases in which it occurred: In one it was the result of an ascending septic thrombophlebitis of the hemorrhoidal veins (a Salmonella montevideo bacillus) and in the other the result of propagation from an old portal vein thrombosis. A splenorenal shunt was performed in each instance.

Death in one of the two cases of postoperative hematemesis was the result of a bleeding peptic ulcer. The large portal vein to vena cava anastomosis was noted to be patent at necropsy. The other case was complicated. The splenorenal shunt was occluded by an unorganized clot, which had presumably occurred before

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death, but there had been considerable abdominal distention, and there had also been extreme respiratory distress, the result of laryngeal obstruction.

Table 2 illustrates some of the possible etiologic factors in the 79 cases of cirrhosis. Unhappily, the uncertain group is large.

Table 3 is of interest, showing the major indications for operation and the duration of symptoms. Whereas

TABLE 5.—*Type of Shunt in Patients with Cirrhosis of Liver*

	Living Patients	Died Postoperatively	Died During Follow-Up	Total
Portal vein to vena cava	28	7	3	38
Splenic vein to renal vein	22	7	9	38
Umbilical vein to vena cava	..	1	..	1
Portal vein to right renal vein	..	1	..	1
Inferior mesenteric vein to vena cava	1	..	..	1
	51	16	12	79

ascites was present in variable amounts at operation in 24 cases, it was considered to be a major indication in only nine. However, in several of these cases there had been also a history of one or more attacks of hematesesis. There were two postoperative deaths in the nine cases, one of them due to an unrecognized bleeding ulcer. The seven patients followed were relieved of their ascites, and one qualifies as the patient with the longest follow-up (operated on April 24, 1945).

Table 4 separates the cases according to sex. Though the number is too small to be of statistical significance, it would seem that the female sex is the stronger, with an incidence of postoperative deaths of 16.6 per cent, as against 20.9 per cent for the males, and an incidence of follow-up deaths of 11 per cent, as against 18.6 per cent for the males.

In table 5 the different types of portacaval shunts employed are portrayed. The portal vein to vena cava type of portacaval shunt and the splenic vein to left renal vein type were employed in 38 cases each. The operative mortality has been the same in the two groups. The follow-up mortality rate is 8 per cent (three cases) in the portal vein to vena cava group and 23.7 per cent (nine cases) in the splenorenal group.

Table 6 presents the causes of death in the follow-up group. Hematemesis was the primary cause of death in five cases. The splenorenal shunt was closed in all five. Hematemesis complicated terminal hepatic failure in two additional cases in which the splenorenal shunts

TABLE 6.—*Cause of Death in 12 Patients Who Died During Follow-Up*

	Number of Years After Operation						
	¼	½	1	2	3	4	5
Hematemesis—shunt closed	..	..	2	..	1	1	1
Hepatic coma—shunt open (hematemesis)	1	..	..	1	..	..	..
Hepatic coma (shunt closed 1, unknown 1)	..	1	..	1	..	..	..
Hemochromatosis—shunt open	..	..	..	..	1	..	..
Pulmonary embolus	..	1	..	..	..	..	..
Perforated ulcer	..	1	..	..	..	..	..

were open. In one of these cases the common duct was completely blocked by small calcium bilirubinate stones; menadione sodium bisulfite (hykinone*) and prompt surgery might have saved the patient. That extreme hypoprothrombinemia, the result of terminal hepatic failure, predisposes to hemorrhage from any site is well known.

To summarize, the patients who hemorrhaged, the patients who died in hepatic coma whose shunt was closed and finally the patients who died after operation and in whom the shunt was thrombosed total nine, or 11.5 per cent of the 79 operated on. We realize, being familiar with the desperate situation that confronted many of these patients, that much has been accomplished.

It is fortunate, on the other hand, that in cases of cirrhosis of the liver the portal vein is regularly available for shunting purposes. In the 38 instances in which it was anastomosed to the vena cava there was but one case in which there was recurrence of gastrointestinal hemorrhage. Failure was expected in this case, but a successful splenorenal anastomosis was established. Within a few weeks following the second operation all x-ray evidence of esophageal varices had disappeared. The patient had had a recent partial thrombosis of the portal vein over which the intima had not grown.

Esophagrams made after a barium swallow. Left, before operation; right, 23 days after a side to side anastomosis of the portal vein with the vena cava. The 39 year old woman with cirrhosis of the liver had 12 severe attacks of hematemesis during the six months prior to operation.

The portal vein in cases of cirrhosis is strong and uniformly of good size. It affords a large anastomosis when joined with the vena cava, and one can depend on its remaining permanently patent. Because of the large size of the shunt the portal pressure is reduced to a figure approaching normal, and esophageal varices regularly become smaller or disappear entirely (see accompanying figure).

An enlarged spleen will regularly shrink to such a size that it can no longer be palpated after anastomosis of the portal vein to the vena cava. Whereas the rate of decrease varies in different patients, the average large spleen will be no longer palapable one to one and a half years following operation. Likewise, there is a variability in platelet response; a substantial rise occurs in most cases, but only occasionally does the number reach a low normal. Some improvement in secondary anemia is the rule, but there is not the response in white blood cell formation that is observed following splenectomy.

We are presently of the opinion, however, that there are certain patients with cirrhosis of the liver who will benefit by the more prompt response achieved by means of splenectomy and a splenorenal shunt. Whereas experience in the past has shown that there is less uniformity of success with the splenorenal portacaval shunt than with the portal vein to vena cava type, nevertheless the over-all results are good, and we believe that they can be further improved.

Table 7 affords a most interesting correlation of the portal pressures with esophageal varices in 18 cases of cirrhosis before and after operation. The portal pressure measurements taken before and after the completion of the anastomoses leave no doubt as to the efficacy of either the splenorenal or the portal vein to vena cava type of portacaval shunt, the general trend being the higher the portal pressure the greater the drop following opening of the shunt. Likewise, the cases having the higher portal pressures generally have more extensive esophageal varices.

TABLE 7.—*Correlation of Portal Pressure Before and After Establishment of Shunts with Preoperative and Postoperative X-Ray Evidence of Esophageal Varices*

Portal Pressure, Mm. Saline				X-Ray Evidence of Esophageal Varices	
Before Shunt	After Shunt—Open	Difference	Type of Anastomosis *	Preoperative	Postoperative
370	235	135	SR ES	3+	1+
465	190	275	PC SS	3+	0
565	220	345	PC ES	3+	0
325	270	55	SR ES	2+	1+
460	190	270	SR ES	2+	0
540	220	320	PC SS	2+	0
450	240	210	SR ES	2+	0
400	120	280	PC ES	3+	1+
680	250	430	PC ES	4+	1+
260	190	70	PC ES	2+	2+
360	160	200	PC ES	3+	2+
340	220	120	PC ES	2+	1+
360	140	220	PC ES	3+	2+
290	240	50	PC ES	1+	0
380	205	175	PC ES	2+	0
480	225	255	PC ES	3+	0
255	180	75	PC ES	3+	1+
380	260	120	PC ES	4+	1+

* SR ES signifies splenorenal end to side, PC SS portal vein to vena cava side to side and PC ES portal vein to vena cava end to side.

TABLE 8.—*Percentage Change in Postoperative Levels From Preoperative Values in Thirty-Three Cirrhosis Cases*

	Sulfobromophthalein, %	Cephalin flocculation, %	Thymol Turbidity, %	Serum Albumin, %
Increased	45	24	20	32.6
Decreased	48	34	19	58.7
No change	7	42	61	8.7

Our goal at the onset was to alter the natural history of cirrhosis of the liver in one respect, namely, to prevent untimely death from hemorrhage or from wasting ascites. When the fact is established that successfully accomplished portacaval shunts will do just this, the question arises of whether the disease process in the liver proceeds at a slower pace once the drain of repeated hemorrhage and wasting ascites is eliminated. Although some evidence is accumulating in the affirmative, only a large and protracted follow-up experience will finally settle this question. Certainly the short term observations on certain liver chemistry determinations as portrayed in table 8 are equivocal. A more detailed correlation of chemical data on the liver with the clinical status would be of extreme interest but is beyond the scope of this paper.

We are glad to report that 47 of the 51 patients with cirrhosis being followed are active and leading essentially normal lives. Activity is restricted in four patients, three of whom are steadily improving. In one case only was there a suspicion of bleeding. The patient, a nervous young man, promptly came to the hospital reporting that he had passed a tarry stool. His suspicion was not confirmed; the next stool was guaiac negative, his blood count was normal and the esophagram was negative for esophageal varices.

SUMMARY

The problem of preventing death from gastrointestinal hemorrhage, the result of portal hypertension, is reviewed. The rationale of the portacaval shunt as a procedure to affect directly the portal pressure and thus prevent the serious effects of portal hypertension is discussed. An operative experience embracing 111 cases of portal hypertension is reported, with detailed analysis of 79 cases of cirrhosis of the liver.

ABSTRACT OF DISCUSSION

DR. HAMILTON SOUTHWORTH, New York: The portacaval shunt represents a real advance in the treatment of one of the most serious complications of cirrhosis. Dr. Blakemore has modestly emphasized his failures, but I am impressed by the fact that among his 38 portal vein to vena cava shunts, though the postoperative mortality is 18 per cent, as it is in the splenorenal shunts, only 1 patient has so far had another hemorrhage. I should like to emphasize the importance of preoperative care and of selecting just the right moment for surgery in these cases. The patients should have at least two weeks in the hospital before operation, with rest, a high calory, high protein diet and supplementary B complex vitamins. Vitamin K is given to those with prolonged prothrombin times, with some benefit. For those with serum albumin values as low as 3 Gm. per 100 cc., intravenously administered human albumin is a great boon provided the expense can be defrayed. Operation should be performed only after the total circulating red blood cell volume has been restored to normal by transfusion, and it should be definite that there is no active bleeding at the time. The poorer risk patients with serious active hepatic disease as well as portal hypertension require prolonged preoperative care. Those with postnecrotic cirrhosis often have exacerbations and remissions of their hepatitis, and surgery should be delayed till a quiet phase is reached. When the cirrhosis has an alcoholic background, maximal medical improvement is often not reached till after three or more months of a carefully planned regimen. I am interested in the high incidence of hepatitis as the presumed cause in Dr. Blakemore's cases of cirrhosis (33 of 79 cases). Usually the incidence of the postnecrotic or coarse nodular variety in large series of cirrhosis cases is from 5 to 12 per cent. Probably we have been seeing the late complications of the increased incidence of hepatitis during and after the war, but certainly there is good evidence that coarse nodular cirrhosis is an effective cause of portal hypertension. Dr. Blakemore has evidence that a successful portal vein to vena cava shunt will often cause a decrease in the size of the spleen and an improvement in the blood values. However, occasionally the hypersplenism part of the syndrome is so marked that splenectomy sooner or later is advisable. In some of these cases Dr. Blakemore has preferred splenectomy and a splenorenal shunt rather than the portal vein to vena cava anastomosis.

DR. C. STUART WELCH, Boston: The late results of portacaval shunts which Dr. Blakemore reports give us assurance that the rationale of decompression of the portal system is as sound as it seems reasonable. I should like to comment on the indications for portacaval shunt and reemphasize some of the points which Dr. Blakemore has made. The operation is indicated primarily in patients who have had hemorrhage from portal hypertension and varices. It is almost an exclusive indica-

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tion, since ascites is not best treated by this method. The contribution which portal hypertension makes to the formation of ascites is unknown, but we do know that high degrees of it may exist without ascites. Certainly portacaval shunts are not indicated in patients who have not bled and who have no varices and whose principal difficulty is poor liver function and ascites. One must surely establish the fact that portal hypertension is the cause of bleeding in every case. I refer to the importance of ruling out whether or not a prothrombin deficiency exists in any bleeding patient. The question of whether or not portacaval shunt is indicated in two other instances also comes up. First, should it be recommended after the first bleeding episode? Second, should it be recommended in patients in whom varices have been demonstrated with the portal hypertension but who have not bled? The answers are difficult to give, but I believe Dr. Blakemore would agree that in patients who have bled once but in whom the spleen is not large and in whom there is no high degree of hypersplenism portacaval shunt may be delayed. If there is a marked degree of hypersplenism, however, indication exists for operation, namely, splenectomy and splenorenal anastomosis, even in patients who have never bled. Dr. Blakemore has shown that portal vein to vena cava anastomosis is more efficient; the results have shown bleeding in a much smaller number of patients after this operation than after the splenorenal shunt. The size of the portacaval anastomosis is larger, and it may be that splenorenal anastomosis does close off more easily. However, there are several advantages to the splenorenal anastomosis. First, with removal of the spleen there is an immediate cure of the hypersplenism. Second, I believe the splenectomy and splenorenal operation is the better procedure for the surgeon beginning this type of surgery. Lastly, portacaval anastomosis can always be done if splenorenal anastomosis fails.

DR. EMILE HOLMAN, San Francisco: I wish to present a new abdominal approach to the region of the common duct and the portal vein, which we have used both for the reconstruction of the common duct and for portacaval anastomosis. The skin incision runs parallel to and about 2 cm. below the costal margin and is extended downward and vertically to about the level of the umbilicus and upward over the lower end of the sternum for about 8 cm., where the skin is reflected laterally. The costal cartilage opposite the fifth interspace is removed for about 2 to 3 cm. and the incision carried through the perichondrium and the intercostal muscles and occasionally through the diaphragm into the chest. The round ligament of the liver is divided and the liver displaced laterally and upward, revealing the structures directly below the incision. We are working over the site of the anastomosis, not from the side, and the operation can therefore be performed with much greater ease. In a man of 65 who had had many hemorrhages the operation was performed readily through this incision. Incidentally, he had been drinking 2 quarts (2,000 cc.) of liquor daily since the age of 30. I should like to ask Dr. Blakemore to what he ascribes these great dilatations of the lymphatic vessels which we almost invariably see in this region. Occasionally we find that localized hyperplasia of the liver prevents the side to side anastomosis, necessitating complete division of the portal vein and its implantation into the side of the vena cava. We also find that the half circle bronchial clamp, with cotton or silk wrapped around it to prevent slipping, lends itself admirably to the tangential oclusion of the vena cava.

DR. ARTHUR H. BLAKEMORE, New York: Dr. Southworth has given us some good advice about the preparation of these patients. Dr. Welch has made contributions to the question of decision as to what type of portacaval shunt to use. He has brought out the important things that make one decide. Dr. Holman's operative approach is an interesting variation. One possible criticism is that he approaches the portal vein from an anterior position. This is the approach with which we have had much difficulty in the past. There are cases of portal hypertension in which the portal vein is rendered unfit for shunting purposes because it is itself the seat of block. If in such cases the splenic vein has been destroyed by a previous splenectomy, it is necessary to employ some other portal radical for shunting purposes. In these circumstances Dr. Holman's operative approach would seem a good one, for example, for exposing the coronary vein.

INTERNSHIP APPOINTMENTS

MATCHING OF PREFERENCES OF STUDENTS AND HOSPITALS

F. J. Mullin, Ph.D., Chicago

The idea of arranging internship appointments by matching of preferences of students with the preferences of hospitals on a national basis is not a new one. Limited matching plans have worked successfully in Canada and also in local areas in this country for some years now. The present plan is merely one of a number of possible ways of achieving the advantages of central matching. It was presented in some detail in the November 1950 issue of the *Journal of the Association of American Medical Colleges* as "A Proposal for Supplementing the Cooperative Plan for Appointment of Interns." A National Inter-Association Committee on Internships has been organized under the sponsorship of the Committee on Internships and Residencies of the Association of American Medical Colleges. It is composed of representatives from the American Catholic Hospital Association, the American Hospital Association, the American Medical Association, the American

TABLE 1.—*Disparity Between Numbers of Graduates and Internships*

	1941	1950	Percentage of Increase
No. of approved hospitals.....	735	799	8.7
No. of internships offered.....	6,874	9,308	36.7
No. of medical school graduates...	5,275	5,553	5.3
No. of internships in excess of no. of graduates.....	1,599	3,845	...

Protestant Hospital Association and the Association of American Medical Colleges, with liaison members from the governmental agencies concerned with internships. Funds to make possible a trial run of this plan on an experimental basis this year have been supplied by the Association of American Medical Colleges. It will be completely independent of the regular cooperative plan. Actual notification of applicants and acceptance of offers are being carried out this year by the usual procedure rather than through the matching plan of the National Inter-Association Committee on Internships. The matching process is being conducted simultaneously as a "dry run." The committee has been set up for the specific purpose of conducting this experiment for this year only.

Before presenting some of the committee's experiences in trying to implement this plan, I would like to point out one reason why this or any other such plan will not solve the internship problem. Table 1 shows the growing disparity between the number of available graduating students and the number of interns desired by the hospitals of the country. It is obvious that with this type of situation prevailing many hospitals are of necessity disappointed, that many of them will resort to undue pressure on applicants in order to try to fill their vacancies, and also that many of them will be suspicious of the medical schools and the methods of their

Chairman, National Inter-Association Committee on Internships.

Read before the Council on Medical Education and Hospitals, American Medical Association at the Forty-Seventh Annual Congress on Medical Education and Licensure, Chicago, Feb. 12, 1951.

more successful competitors in securing interns. As table 2 indicates, the situation is rapidly growing worse with an even wider gap between available applicants and the number of interns desired; this is partly due, of course, to the loss to the military of resident staff who do much of the service work of the hospital. It should be pointed out that the significant figures in this table are based on incomplete returns from the hospitals.

The problem is also largely one of the competition between the professor in the teaching hospital and the community hospital administrator. The former puts great pressure on students to sign up on his service in order to carry on his special interest or program, while the latter is being hounded to secure relatively inexpensive service help for a group of private practitioners. The internship is neither solely medical service nor solely learning; it should be essentially a reasonable combination of these factors in which service is rendered in exchange for learning opportunities. The increasing clinical experience available to students in their medical school clerkships as now constituted in most schools has lessened that aspect of the value and necessity of internship training. This is particularly true of the more

TABLE 2.—*Increase in Number of Internships Offered by 230 Hospitals for July 1, 1951* *

No. of internships offered in 1951	4,395
No. of internships offered in 1950	3,610
Increase in 1951 over 1950	785 †

* Of the 764 hospitals reporting from a total of 809 approved hospitals, 230 institutions are planning increases in internships.

† A little less than half of the increased number of internships to be offered this year are accounted for by the teaching hospitals, which, according to student reports, are the worst offenders in trying to pressure students into early commitments. About five times as many increased places are being offered by hospitals already having 10 or more internships than those with less than 10.

restricted kind of internship in which the intern is not given expanding opportunity and responsibility commensurate with his growing knowledge and ability. The whole internship picture will get worse, however, unless some clearcut decisions are made as to the role of the internship in the total educational experience of the new physician and unless some honest efforts are made in real cooperation among the various groups responsible in some degree for the internship training period.

PROPOSED PLAN

The plan presented involves, first, making an accurate and exact directory of the internships available each year. The experience of the committee so far has shown that it is almost impossible to set up a decent matching procedure without specific knowledge of exactly what is available. We have had to attempt to do our work this year without such a directory because of the lack of time to prepare one. While such a directory is necessary for accurate mechanical matching, its main value will be the educational one of informing students of just what opportunities are really open to them. We have now heard from all except six of the approved hospitals in this country. All the other 803 approved hospitals either have returned our questionnaire or have promised to do so shortly.

We have asked the dean of each medical school to secure the cooperation of his senior students in ranking the hospitals to which each has applied in order of preference. The returns from the students have not been nearly so complete as those from the hospitals. This is because some students are confused; some lack the ability to make up their minds until a decision is actually forced on them, and some are afraid that such information will be made available to hospitals. It goes without saying that the preferential order of the student's ranking of the hospitals to which he has applied must be kept in absolute confidence and not under any circumstances passed on to the hospitals. We have had indications that part of the difficulty in obtaining a more complete student response has been due to the failure of some deans to explain the plan adequately to their students. In a few instances, it was because of the dean's inability to secure the wholehearted cooperation of his students. It should be emphasized that for a completely dependable test of the matching of preferences of students and hospitals, a ranking form is required from each senior who is applying for an internship. We still hope for complete returns for this year. If this plan should be adopted for official use sometime in the future, the students would return their ranking forms directly to the central office. This should spare the dean some trouble and relieve the student from worry about local pressures put on him to accept an internship in one of the school's teaching hospitals.

Rating sheets and stamped return envelopes have been sent to all hospitals approved for internships. The information previously supplied by the hospitals has been used to determine the type of internships available and the number offered. The hospitals are asked to list and rate their applicants for each different kind of internship offered, using one of the following five categories defined on the blanks: (1) most desirable (the number of such designations not to exceed the number of available places); (2) desirable (the number of such designations not to exceed twice the number of available places); (3) acceptable; (4) acceptable only if all other applicants are exhausted and vacancies remain; (5) not acceptable.

If this system is used another year the hospitals will be supplied with an alphabetical list of their applicants as reported by the students to the committee. The preferential standing of any hospital will not be sent to it, of course. It was necessary to omit this step this year because of the delay, first, in getting the complete information on the types and numbers of internships available at each hospital and, second, in getting the ranking lists or even the names of the hospitals to which the student applied.

It will be possible in the future to set up the procedures in such a way that completely accurate lists can be obtained beforehand, and thus the process can be facilitated tremendously. The hospitals have been asked to return their rating forms by February 15. Only if the ratings are returned promptly by every hospital having applicants can a reasonably quick matching be made and a fair trial of the experiment be obtained. Even though a valid test of this internship placement pro-

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cedure, which may have advantages for both students and hospitals, is not possible this year, much experience has been gained by the National Inter-Association Committee on Internships and its staff. We now know much more than we did about the internships that are available and the procedures necessary for the working of a matching plan that will be fair to all concerned. We will make every effort to make this "dry run" a significant experiment, however, and we hope for the continued cooperation of everyone involved. We feel that the knowledge and experience gained so far would in itself justify the extensive work that has been done up to now.

The information obtained from both students and hospitals is being punched on I. B. M. cards for mechanical matching of the expressed choice of each. Table 3 illustrates the order in which the matching will be made, as agreed on by the Committee at its first meeting.

It will be seen that after the "one-ones" are matched and removed from consideration, the "two-ones" are

TABLE 3.—*Illustration of Order of Matching by Hospital Rating and Student Ranking*

Hospital Rating	Student Ranking
1	1
2	1
1	2
2	2
3	1
3	2
1	3
2	3
1	4
2	4
3	3
3	4
1	5
2	5
1	6
2	6
3	5
3	6

matched, and the procedure continues in order until the first three choices of the students have been filled, provided the given hospitals rated a particular student as "acceptable." The cycle is repeated for the next three choices of the student until all instances in which a student could be matched with a hospital that wanted him have been exhausted. Adequate checks will insure that more students are not matched with a given hospital than it has internships available in any given category. When there are more applicants who rate the hospital equally high and who are equally desirable to the hospital than there are places still available after the "one-ones" have been matched, the matching will be by chance, so that no decisions as to where to place a student or hospital will be made by the central office staff. All policies of the matching procedures will be determined by the Inter-Association Committee. The final step in the matching plan involves the determination of whether there are students available who have been given the fourth rating by hospitals and, therefore, are not to be placed with them unless there are still places available after all other applicants to that hospital have been placed.

After announcement of the matchings, the Committee could notify hospitals of unmatched students and could also inform deans of remaining internships available so that individual negotiations could complete the process. Under the present cooperative plan, there has been considerable pressure put on students in what they consider an unfair attempt to force them to make early commitments and thus limit their opportunities. Many students rightly resent this. While the matching plan just outlined will not in any way limit the freedom of either students or hospitals in making contacts and getting information about each other or in expressing their choice, it should eliminate much of the unfairness and unseemly scramble to sign up students under the present system. The dissatisfaction with the present system is growing and the demands of the national emergency, especially with an accelerated program, will probably make it even more difficult to get real cooperation unless some such plan as that presented here is adopted.

CONCLUSIONS

There are at least three alternatives in the solution of this problem. First, we can return to an unregulated system of signing up students at any time in their medical school career and having them make commitments for a long period in the future. I have been informed that this resulted in a period of much confusion and chaos during the last war. Second, the medical schools might be forced to adopt the requirement of the internship for graduation in order to regulate it. This would involve much work and responsibility and probably considerable confusion also. Third, a real attempt at cooperation among all groups concerned might solve some of the fundamental difficulties in our present situation, and these groups might try to define precisely the proper nature of the internship and determine the best means of obtaining these objectives with a reasonable and fair solution of the placement problems. It is our hope that the present efforts of the National Inter-Association Committee on Internships will help to indicate the solution to some of these problems.

Chicago Medical School, 710 South Wolcott Avenue.

Coronary Occlusion.—It is now 250 years since Theophile Bonet published the description of a fatal case of coronary occlusion, 182 years since Heberden's classical account of angina pectoris, 151 years since Parry published Jenner's letter relating angina pectoris to coronary artery disease, and 38 years since Herrick established the clinical picture of myocardial infarction. Yet only now, very belatedly, are we physicians beginning to undertake in anything like an adequate degree fundamental researches into the cause of the serious coronary artery atherosclerosis which is without doubt the most important of the threats to the health of man in civilized countries today. This disease has changed the course of history of families, communities, states, nations, and even of the world itself by crippling or killing some leader or group of leaders at the height of their careers in business, profession, or government. Of all kinds of heart disease it is the most important, not only because it is common the world over and serious but also because a concerted effort to discover its cause, or causes, has been so tardily established.—Paul D. White, M.D., Coronary Heart Disease in Midcentury with a Note Concerning its Military Importance, *United States Armed Forces Medical Journal*, March 1951.

CLINICAL NOTES

DDT (DICHLORODIPHENYL-TRICHLOROETHANE)

Theodore T. Stone, M.D., Chicago
and
Lee Gladstone, M.D., McHenry, Ill.

The following clinical note presents the case of a worker exposed to dichlorodiphenyltrichloroethane (DDT) who had a four year illness characterized by neurological disturbances and mild leukopenia. A causal relationship between illness and exposure to DDT is suggested by the fact that the patient improved when taken off his regular job.

REPORT OF CASE

B. S., a 24 year old man, was seen first on May 20, 1950, complaining of weakness of four years duration, poor appetite and restless sleeping. His condition occurred in paroxysms until May 16, when he observed a distinct increase in weakness and an indistinction in his speech, so that he was not understood by his associates. He remained home for two days and then returned to work on May 19. On June 2 his fatigue became marked and severe. When first examined by one of us (L. G.) he complained of the following: severe fatigue, difficulty in talking clearly, glare phenomena, photophobia, blurring of vision and a feeling as though he were swimming and walking on air. At times he walked as if he were drunk, although he did not and does not drink any alcoholic liquids. On June 3 neurological examination (by T. T. S.) revealed a positive Romberg sign, unclear and indistinct enunciation of words, severe photophobia, decrease of deep reflexes in the upper and lower extremities, tenderness along all the nerve trunks and clumsiness in the upper and lower extremities. The gait was reeling and titubating; he had to hold on to the side of the walls to prevent falling; there were no clonus or pathological reflexes, although there was clumsiness in approximating the heels to the opposite knees and the tip of the index finger of each hand to the tip of the nose, and sensation was normally present throughout the entire body. Examination of cranial nerves revealed only marked photophobia and blurring of vision with glare phenomena. No vestibulocerebellar signs were found. Laboratory studies revealed a white blood cell count of 5,200, with 29 per cent polymorphonuclear leukocytes, 70 per cent lymphocytes and 1 per cent monocytes. The spinal fluid was normal. A roentgen examination of the skull showed no abnormalities.

The patient stated that at the time of the onset of his illness he was employed in making DDT aerosol bombs. In an effort to increase his output, he became careless in filling the bombs and neglected to place the bomb and chemicals in the protective enclosed glass cubicle. As a result, for four years he was exposed to vaporizations of the DDT formula for eight hours every working day. The patient was hospitalized for four days and then remained in bed at home for 10 more days. He received 500 mg. of nicotinic acid daily for three days, and 150 mg. of thiamine hydrochloride was injected daily for six days. He was given a palatable high caloric and high vitamin diet, and after 14 days of absolute bed rest he made an excellent recovery. At this time blood studies revealed a red blood cell count of 4,970,000, with a hemoglobin content of 90 per cent, and a white blood cell count of 7,600, with 42 per cent polymorphonuclear granulocytes, 36 per cent lymphocytes, 3 per cent monocytes, 1 per cent eosinophils and 2 per cent basophils. He returned to work and has been there every day to date. He reports enthusiastically that he feels better now than any time in the past four years.

COMMENT

When this patient was taken away from his work his signs and symptoms of weakness, visual disturbances, decrease or absence of deep reflexes and leukopenia vanished. They did not reappear after he returned to work and observed the recommended safety precautions that were previously ignored. In the plant where our patient worked the aerosol bomb consisted of DDT, 2 per cent pyrethrum, 5 per cent piperonal butoxide and 12 per cent freon. The amounts of pyrethrum, piperonal butoxide and freon as existing in the aerosol bomb made by our patient are not enough, according to Kehoe, to individually produce deleterious effects. Wright, Doan and Haynie,[1] however, reported a case of agranulocytosis following exposure to an aerosol bomb (insecticide) that they believed was attributable to DDT. Central nervous system disturbances are known to occur with DDT poisoning.[2] However, it must be admitted that the possibility exists that one or more of the other ingredients may have been a major or a contributory factor in this patient's illness.

30 North Michigan Avenue, Chicago.
308 South Green Street, McHenry, Ill.

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From the Department of Nervous and Mental Diseases, Northwestern University Medical School; The Division of Neurology and Psychiatry of Wesley Memorial Hospital, Chicago, Woodstock Public Hospital, Woodstock, Ill.

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COUNCIL ON NATIONAL EMERGENCY MEDICAL SERVICE

This paper is one of a series requested by the Council on National Emergency Medical Service to inform the medical profession on problems pertaining to civil defense. It does not necessarily reflect, however, the opinions of the Council or of any other official body unless so stated in the article.

C. JOSEPH STETLER, *Secretary.*

ATOMIC BURN INJURY

Everett Idris Evans, M.D., Richmond, Va.

Thermal injury (burns) will constitute a major medical problem in atomic attacks on any large American city. Burn casualties in the thousands should be expected and their care planned for. This medical care, to be truly effective, must have as its chief objectives the saving of the largest number of lives by the simplest means (in terms of materiel and personnel) and return of as many injured persons as possible to useful work in the war effort. Should atomic attacks on our cities come, we will be fighting for our very survival as a nation of free people.

Informed and brave free men can contemplate destruction from the skies somewhat calmly; trained free

From the Department of Surgery, Medical College of Virginia.
Chairman, Subcommittee on Burns, Member of the Committees on Surgery and Atomic Casualties, National Research Council.

men, putting first things first, can effectively minimize damage by fire if they will only apply what is already known about the prevention and treatment of burns. I propose here to report briefly on the available information and to sketch out the training necessary for adequate defense against atomic burns.

THERMAL HAZARDS OF THE ATOMIC BOMB

The area immediately beneath the air burst of an atomic bomb is subjected to the combined effects of blast, gamma and neutron radiation and intense heat. The devastation here will be so great as to result in practically total loss of life (immediate or delayed); so medical attention must, in the main, be directed to the survivors outside the 1.4 kilometer (1,500 yard) zone, i. e., from 1.4 to 3.7 kilometers (1,500 to 4,000 yards)..

Thermal injury in survivors outside the hypocenter zone will be of three types: the "flash burn," contact burns from spontaneous ignition (or heat transfer to skin) of clothing and deep burns from direct contact with flame encountered during entrapment in or escape from burning buildings.

The atomic "flash burn" differs from ordinary burns of civilian life only in that it results from exposure of the skin to a large amount of radiant energy (infrared, visible and ultraviolet) in a very short rather than a long period of time. Flash burns are not uncommon in civilian practice, being encountered usually in gas explosions; they involve only the exposed surfaces of the body, usually only the face and hands or legs in women and children. Close to an atomic bomb blast these burns would be deep (third degree) because of the large amount of heat energy absorbed; farther out (2.4 to 3.7 kilometers [2,500 to 4,000 yards]) these flash burns are superficial, resembling sunburn (first degree), or deeper, in which case blisters form (second degree). First and second degree flash burns are painful, full thickness burns less so. Flash burns of the superficial variety, properly treated, should heal readily.

Contact burns in atomic bomb explosions result from spontaneous ignition of inflammable clothing (certain cottons and artificial silks) or the ready absorption and transfer of large amounts of heat by darker clothing. Light-colored cloth reflects heat rays better than dark cloth and so is less dangerous to the wearer. Flash and contact burns result only from exposure to the heat rays of the bomb in persons out in the open. A properly warned and adequately trained population should not be in the open during a forewarned atomic attack. Those who must necessarily be in the open should be wearing clothing not readily ignited by heat rays. Ordinary light-colored wool meets this requirement.

Secondary burns encountered in escape from burning buildings will be similar to those serious extensive burns seen in civilian practice. It is this group that will demand more expert medical care, especially as they might be associated with other serious injury (e. g., fractures).

EMERGENCY MANAGEMENT OF THE BURN PATIENT

The details of emergency burn care that I consider important are (1) evaluation of extent of injury; (2) relief of pain; (3) emergency dressings; (4) prevention and treatment of burn shock; (5) salt and water requirements to insure adequate urine output, and (6) antibiotic therapy.

1. *Evaluation of Extent of Burn Injury.*—Instructions to lay and medical personnel for emergency care of mass burn casualties should describe in some detail just what constitutes a serious burn casualty. To mention only a few points, the first aid worker must determine roughly the extent of the burn injury, because if the burn covers about 10 to 15 per cent of the body surface immediate attention must be given to the prevention of burn shock; in burns of the face possible pulmonary damage must be ruled out by examining the nares and pharynx and noting hoarseness of the speaking voice; associated injuries, such as a fracture, must be sought, and on the burn victim's identification card should be placed information as to his location at the time of bombing, because, although in the 1.9 to 2.1 kilometers (2,100 to 2,300 yards) zone the gamma ray dosage may be considered by some to be insignificant, with associated burn injury it may prove highly important as a complicating factor in the later clinical course of the patient. Space does not permit discussion of all the details of this type that must be taught to the first aid worker.

These may prove to be somewhat complicated matters to teach first aid workers, but unless such teaching is accomplished, triage and evacuation will be neither efficient nor effective. Expert medical aid must be reserved for those burn victims who really require it.

2. *Relief of Pain.*—Pain is readily relieved by an adequate covering dressing or, in the case of the face, somewhat relieved by the application of an oily or greasy salve. Morphine sulfate in small amounts may be required with an additional short-acting barbiturate to relieve anxiety.

3. *Emergency Dressings.*—Small burns of the extremities (even hands) can be treated efficiently by lay persons who have been properly taught how to cover the burn wound with a simple first aid dressing. Burns of the face, if painful, are simply treated by the application of a salve. I believe it unwise to advocate occlusive dressings for burns of the face in mass casualties, because burn casualties so treated are unable to care for themselves.

In principle, the burn wound is covered with an emergency dressing, because the dressing relieves pain; it helps to prevent contamination of the burn wound and thus minimizes infection; it allows some immobilization of the burned part; its use permits ready transfer of the burn patient as a walking casualty, or by ambulance, train or airplane; its use does not clutter up hospitals with burn casualties who sometimes can be better cared for in simpler surroundings. If left alone most superficial flash burns heal readily.

Emergency dressings of a single piece type, simple enough to be applied rapidly to limb or trunk burns by trained first aid workers, will soon be available for civil and military use. Experience at the clinic of the Medical College of Virginia has shown that they can be left in place for as long as 14 days without soaking through. They have been highly effective. An equally simple and

efficient dressing for the burned hand remains to be developed. The emergency dressing does not prohibit the subsequent employment of the exposure method for the treatment of those burned seriously enough to require hospitalization, should adequate clinical experience with the method prove its value for mass casualty burn treatment.

In the event that an atomic attack results in several thousand burn casualties it is very possible that sufficient supplies of emergency burn dressings will not be readily available. For this reason, physicians must acquaint themselves with the details of the "exposure method" for burn care by reading the published reports of Wallace, Pulaski and Blocker. This apparently simple method if not correctly employed could easily become in practice a method of "surgical neglect." If correctly employed, however, with an understanding of its advantages and disadvantages (all burn methods have their disadvantages), the exposure method might result in saving the lives of many burn casualties after atomic attack. Indeed, if supplies of bandages were not available, it might prove the only feasible method to use for the burn casualty.

4. *Prevention and Treatment of Burn Shock.*—Shock in the severely burned patient is caused mainly by the loss of plasma and some red cells into the burned zone with resultant diminished blood volume, soon followed by a sharp drop in cardiac output. In the young adult burn shock rarely occurs unless at least 15 per cent of the body surface is involved, but in the very young and aged I have seen shock with less than this amount of body surface burned. Therefore, in mass casualty teaching I would prefer to say that shock may be anticipated in a body burn of more than 10 per cent. In my experience shock is prevented by the timely intravenous infusion of adequate amounts of plasma (or plasma substitutes) in patients with burns covering as much as 25 per cent of the body surface. With more extensive burns I prefer to give equal parts of plasma (or plasma substitutes) and whole blood. In the more extensively burned every effort should be made to anticipate shock and prevent its occurrence by the early administration of adequate amounts of colloid.

Rather wide experience with gelatin and dextran (6 per cent solution of polydispersoid glucose polymer) indicates to my colleagues and myself that these plasma substitutes are safe and effective. Oral administration of the physiological salt solution advocated by Moyer is, in his experience, effective in preventing shock in the less severely burned. Simple formulas for colloid requirements of the burned patient in the first 24 hours are now developed, and it seems likely that the adequacy of shock treatment for mass casualties in burns may well be measured by the simple observation of hourly urine output. A training program to teach intravenous therapy methods for the shock patient to thousands of physicians and nurses should be instituted at once so that a sufficient number of persons trained in the details of this therapy will be available after atomic attacks.

5. *Salt and Water Requirements to Insure Adequate Urine Output.*—Our experience indicates that approximately equal volumes of salt solutions and colloids are required to meet the salt and water requirements of the burned patient. If salt can be taken by mouth, as suggested by Moyer, it should be given in this manner. In our experience severely burned patients do not ingest adequate amounts of fluid and salt by mouth, so these are given by the intravenous route. Water is given in sufficient amounts to insure an hourly urine output of approximately 50 cc. in the adult and less in the burned child. (A simple method should be developed that would allow the patient to determine for himself the hourly urine output.) Every attempt should be made to meet these requirements during the first 24 to 36 hours; after that time the intake of salt is sharply curtailed to prevent subsequent pulmonary edema.

6. *Antibiotic Therapy.*—Penicillin appears to be the antibiotic of choice for mass burn casualties. So far we have used it only by infrequent intramuscular injection, giving from 300,000 to 500,000 units daily in the severely burned. Additional clinical work may prove the feasibility of administering penicillin effectively by the oral route. The same is true of aureomycin hydrochloride and terramycin hydrochloride, which we have used effectively in limited studies in the burned patient. I now do not consider it feasible to employ penicillin locally on the burned wound for mass casualty use.

PERSONNEL REQUIRED FOR MASS BURN THERAPY

In ordinary civilian practice it is now recognized that even a few burn patients constitute a heavy load on the surgical and hospital services of a well organized hospital. Only an efficient organization, lay and medical, will ever be able to handle the problem of mass burn casualties.

In this series of discussions on civilian defense others may have written more extensively on the problem of adequate supplies of whole blood or plasma to treat mechanical and radiation injuries as well as burns. Because one of the first and most urgent needs of the trauma patient is for these substances, Americans must organize at once a system on a national scale that will make readily available large supplies of whole blood and plasma. If stockpiling of large amounts of plasma is not possible, recourse will then have to be made to the stockpiling of plasma substitutes such as dextran or gelatin. These stockpiles must be accompanied by large supplies of needles, syringes and intravenous infusion sets so organized that the equipment is interchangeable with that of other localities.

The personnel required for mass burn therapy, should atomic attacks ever take place on our large cities, may well run into the thousands. Thought should be given now to the training of first aid workers in certain techniques now performed only by qualified medical personnel. Thousands of nurses should be trained at once in the techniques of intravenous infusion therapy. Because enough nurses may not be available for such tasks, thought should be given to the training of a special group of lay persons for such work. Such therapy may have to be given at the scene of catastrophe before the patient can be moved, and nurses may not be available for such work.

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The important groups of personnel necessary for this work are (1) rescue workers, (2) first aid workers and (3) medical personnel.

Under the direction of the National Red Cross, the training of thousands of rescue and first aid workers should be started without delay. Rescue squads similar to those developed in England during the past war will be needed to extricate victims from burning buildings. First aid workers trained to put on simple burn dressings at the site of the catastrophe should come in soon after the bomb burst has occurred. Other more highly trained first aid workers must be available at first aid stations, where they can place the protective occlusive dressings on the more extensive burns. More highly trained lay personnel and nurses must be available at first aid stations and hospitals to carry out intravenous therapy to prevent or treat burn shock.

Available medical personnel will be so scarce as to demand severe rationing of their services. In every large city several medical men should be trained in the art and science of resuscitation so that they can supervise the treatment of all casualties in shock, whether from other trauma or burns. Burn shock has different clinical features than ordinary traumatic shock, so these resuscitation officers should be acquainted with burns. Surgically trained medical personnel must be available for emergency surgery on the burned casualty who has accompanying injuries. These surgeons must be trained for emergency surgery; definitive surgery may well have to wait.

Should bomb attacks on our cities result in many burn casualties, there will be a tremendous need for early skin grafting in the survivors. Special thought should be given to setting up centers where surgeons highly skilled in the early plastic care of burned hands are available. This will be necessary to insure the early return to work of industrial workers important to the war effort.

Finally, if bomb attacks are expected we would be wise to give consideration to the setting up of special burn centers in strategically located cities in the several parts of this country. Without these, efficient first aid and later medical care cannot be properly taught and carried out.

SUMMARY

A brief discussion is given of the thermal hazards of an atomic bomb explosion as it might affect civilian casualty services in an American city. Some details of emergency management of the burn patient are presented. The personnel required for adequate mass burn care are discussed briefly. The need for early organization for the training of first aid and medical workers for this effort is emphasized.

General Practice.—It is remarkable that in this decade of more leisure, shorter working hours and better working conditions, the lot of the family doctor has considerably worsened. In addition to meeting the ever-increasing calls made by his clamorous patients upon his time, he is met by a snow-balling growth of medical knowledge with which he must attempt to keep abreast.—Leigh Cook, General Practice Today: In Urban Areas, *Medical Journal of Australia*, Jan. 6, 1951.

COUNCIL ON PHARMACY AND CHEMISTRY

NEW AND NONOFFICIAL REMEDIES

The following additional articles have been accepted as conforming to the rules of the Council on Pharmacy and Chemistry of the American Medical Association for admission to New and Nonofficial Remedies. A copy of the rules on which the Council bases its action will be sent on application.

R. T. STORMONT, M.D., *Secretary.*

Ethinyl Estradiol (See New and Nonofficial Remedies 1950, page 335).

Elixir Orestralyn: 118.3 cc. and 3.78 liter bottles. A flavored alcohol solution containing 0.004 mg. of ethinyl estradiol in each cc. (U. S. Patents 2,251,939 and 2,265,976). McNeil Laboratories, Inc., Philadelphia, Penn.

Tablets Orestralyn: 0.02 mg., 0.05 mg. and 0.5 mg. (U. S. Patents 2,251,939 and 2,265,976). McNeil Laboratories, Inc., Philadelphia, Penn.

Diphtheria Toxoid and Pertussis Vaccine Combined (Alum Precipitated) (See New and Nonofficial Remedies 1950, page 446).

Diphtheria Toxoid, Alum Precipitated and Pertussis Vaccine Combined: 4.5 cc. vials (three immunizations: three 0.5 cc. injections). 30,000 million *H. pertussis* in each cc. Preserved with thimerosal 1:10,000. Pitman-Moore Company, Indianapolis, Ind.

Dihydrostreptomycin-U.S.P. (See THE JOURNAL, July 8, 1950, page 896).

Dihydrostreptomycin Sulfate: 5 cc., 12 cc., and 20 cc. vials. Dihydrostreptomycin sulfate powder equivalent in activity to 1 Gm., 2 Gm., and 5 Gm., respectively, of dihydrostreptomycin base. E. R. Squibb and Sons, New York, N. Y.

Diphtheria and Tetanus Toxoids with Pertussis Vaccine Combined (Alum Precipitated) (See New and Nonofficial Remedies 1950, page 444).

Infagen: 7.5 cc. vials (five immunizations: three 0.5 cc. injections). 30,000 million *H. pertussis* in each cc. Preserved with thimerosal 1:10,000. Pitman-Moore Company, Indianapolis, Ind.

Diphenhydramine Hydrochloride-U.S.P. (See New and Nonofficial Remedies 1950, page 31).

Powder Benadryl Hydrochloride: 14.17 Gm. vials. Parke, Davis and Company, Detroit, Mich.

Gitalin (Amorphous) (See New and Nonofficial Remedies 1950, page 234).

Tablets Gitaligin: 0.5 mg. White Laboratories, Inc., Newark, N. J.

Methionine (See New and Nonofficial Remedies 1950, page 367).

Capsules Methionine: 0.5 Gm. Ives-Cameron Company, Inc., New York, N. Y.

Diphenylhydantoin Sodium-U.S.P. (See New and Nonofficial Remedies 1950, page 411).

Powder Dilantin Sodium: 28.35 Gm. vials. Parke, Davis and Company, Detroit, Mich.

Diethylstilbestrol-U.S.P. (See New and Nonofficial Remedies 1950, page 331).

Tablets Diethylstilbestrol: 0.2 mg., 0.5 mg., 1.0 mg. and 5.0 mg. Physicians' Drug and Supply Company, Philadelphia, Penn.

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PROPHECIES IN DEVELOPMENTS IN PHYSICAL MEDICINE AND REHABILITATION

In every generation there are leaders of men who seem to be endowed with qualities of leadership and to possess such discerning ingenuity and imagination that they are able to predict accurately the things to come. Two such great leaders who have influenced greatly the development of certain phases of medical practice throughout the past quarter of a century are the late Dr. William J. Mayo and elder statesman Bernard M. Baruch—two men of keen minds and simplicity of character, giants of medical and political statesmanship, both exhibiting that clarity of thought which made it possible for them to predict what would come to pass in connection with the field of physical medicine and rehabilitation.

Twenty-six years ago Dr. William J. Mayo [1] wrote, "Rehabilitation is to be a master word in medicine." Few other physicians in the entire country would have dared to make such a prediction in 1925. And yet, a quarter of a century later rehabilitation did become "a master word in medicine," the American Medical Association had its own Section on Physical Medicine and Rehabilitation and a Council on Physical Medicine and Rehabilitation, and there was an American Board of Physical Medicine and Rehabilitation.

Similarly, seven years ago, Bernard M. Baruch [2] advised the members of the Baruch Committee on Physical Medicine and Rehabilitation: "To develop the field of physical medicine and rehabilitation, you must first train teachers. Within a few years you will have qualified teachers in this specialty in key medical centers all over the United States." At a time when Mr. Baruch's medical advisers were groping toward the development of a program that would advance the medical specialty that he had determined to assist, Mr. Baruch had placed his finger on the core of the problem and foresaw what would come to pass seven years later.

As Dr. Mayo's prophecy was fulfilled, so Mr. Baruch's prediction has come to pass. Since Mr. Baruch made his prediction, one can recall the appointment of at least a dozen capable and well qualified teachers in physical medicine and rehabilitation in medical centers throughout the United States. Only a partial list comes to mind at the moment, but it serves to indicate the accuracy of Mr. Baruch's prediction. Within the past seven years the following outstanding teachers of physical medicine and rehabilitation have served or have been appointed to serve in major centers of medical learning: H. D. Bouman, University of Wisconsin; H. L. Dinken, University of Colorado; F. A. Hellebrandt, Medical College of Virginia; Thomas Hines, Yale University; Frederic Kottke, University of Minnesota; E. M. Krusen Jr., Southwestern University; Sedgwick Mead, Washington University; James W. Rae Jr., University of Michigan; D. L. Rose, University of Kansas; Howard A. Rusk, New York University; Charles Wise, George Washington University, and R. E. Worden, Ohio State University.

The medical profession has seen almost phenomenal development in the field of physical medicine and rehabilitation. It is a new field compared with other branches of medicine, and yet it has had its leaders for many more years than many physicians appreciate. There always is a lag between the early enthusiasm of a few and the general acceptance by many. Some would say a long period is needed for study, lest enthusiasm lead to tragedy. Mayo and Baruch would be the first to urge temperance as experience is gained. However, now that the proper role of physical medicine and rehabilitation has been demonstrated amply, it is with much satisfaction that friends of Mayo and Baruch point to their early teachings. Their prophecies have more than come true; they also serve as inspirational messages for others who have the courage, knowledge and ability to press for medical advances.

1. Mayo, W. J.: Contributions of Pure Science to Progressive Medicine, J. A. M. A. 84: 1465 (May 16) 1925.
2. Baruch, B. M.: Personal communication to the author.

NEUROLOGICAL EXAMINATION

Changes in muscle tonus are of great significance in neurological diagnosis, but routine methods currently in use for their determination are somewhat crude and inadequate. Usually the examiner manipulates the patient's extremities and attempts to appraise the resistance encountered. This method often fails to reveal minimal changes and renders simultaneous comparison in the two extremities difficult. Recently Wartenberg [1] described a more precise and informative test, which he believes deserves adoption as a routine part of every neurological examination. In this simple test the pendulousness of the freely swinging extremity is used as an index of muscle tonus. While the procedure is described for the lower extremities only, it can be adapted to the upper extremities as well. The patient to be tested is seated on the edge of a table with his legs hanging freely. The examiner lifts the patient's legs simultaneously to the same horizontal level and then releases them, allowing them to swing freely. Two aspects of the motion are noted: its duration and its quality. In the normal person the legs usually swing six or seven times before coming to rest, with the

1. Wartenberg, R.: Neurology 1: 18 (Jan.-Feb.) 1951.

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range of successive movement diminishing steadily and evenly. If one leg swings longer than the other, the presence of some abnormality must be assumed. If the difference is slight, several repetitions of the test may be necessary before it becomes apparent. Any voluntary interference on the part of the patient disturbs the characteristic precision and regularity of the movements and can easily be detected. After the swinging time has been determined, the quality of the swing is appraised; the smoothness of the movement and the plane of the swing are studied. Normally the legs swing smoothly in an anteroposterior plane. In disturbances of muscle tonus the movements may be jerky or the foot may move in a diagonal, zigzag or elliptical direction rather than in a straight line.

Diseases characterized by extrapyramidal rigidity, such as paralysis agitans and postencephalitic parkinsonism, produce the most striking disturbance in pendulousness of the legs, namely, a pronounced decrease in the swinging time without obvious qualitative changes. This sign is present early in the diseases mentioned, before the patient complains of symptoms in the extremity and before other simple tests reveal definite abnormality. In spasticity due to pyramidal lesions there is less change in pendulousness than in rigidity due to extrapyramidal lesions. The legs may show all the signs of a pyramidal lesion with little quantitative change in pendulousness except for some increase in the speed of the forward movement and some decrease in the range of the backward movement. Qualitative changes, however, are usually pronounced. The leg does not swing in the anteroposterior plane, and the tip of the foot describes an irregular outline suggesting a flattened ellipse, a broken circle, a spiral or an indefinable figure. Sometimes it is possible to detect spastic hemiparesis on the basis of this test alone. In hypotonia of any origin the swinging time of the affected leg is prolonged. This may occur in lesions of the cerebellum and its connections. If there is a lesion of both the cerebellum and pyramidal system, the cerebellar influence usually predominates and pendulousness is increased. An increase occurs also in any involvement of the lower motor neurone, such as poliomyelitis, progressive spinal atrophy, spinal cord tumor, prolapse of an intervertebral disk, postanesthetic radiculitis in the lumbar region, neuritis of the cauda equina, femoral neuritis, muscular dystrophy and muscular atrophy after knee injury.

Wartenberg emphasizes that pendulousness of the legs should be studied as it occurs after passive elevation of the legs and not after the patellar tendon is tapped to elicit the quadriceps reflex. The motion of the leg following the latter procedure has been called the pendular reflex, but this is a misnomer since pendulousness is a by-product rather than an integral part of the reflex. When the legs are set in motion in this fashion, the swings cannot be compared with precision because it is difficult to tap both patellas with the same force. Moreover the strength of the reflex may be different on each side, or there may be discrepancies between the patellar reflex and muscle tonus. In cerebellar lesions hyperactive reflexes may be associated with hypotonia and in mild pyramidal lesions the patellar reflex may be increased, while muscle tonus and pendulousness are not appreciably altered.

Abnormal pendulousness of the legs may at times be diagnostically decisive; but its chief importance lies in the fact that it alerts the examiner and focuses his attention on possible early organic disturbances, thus leading to further investigation. The test appears to have merit and should certainly be given wider trial.

SUMMER ROUND-UP

During the next 90 days, physicians will be asked to examine the annual increment of kindergarten and first grade children as part of the Summer Round-Up of the Children sponsored by the National Congress of Parents and Teachers. The Summer Round-Up has had the endorsement of the American Medical Association since its inception in 1925. The Director of the American Medical Association's Bureau of Health Education has been a member of the Parent-Teachers Association Summer Round-Up Committee for this whole period and has been largely responsible for developing present policies and standards. During the first 10 years, when the Summer Round-Up Committee had no financial resources, as many as 400,000 examination blanks per year were donated to the P. T. A. by the American Medical Association in the name of *Hygeia* as a contribution to the promotion of child health.

The physicians, educators and health officers who have attended the last two conferences on physicians and schools, sponsored by the Bureau of Health Education of the American Medical Association, the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association, and many others who have considered the health problems of school age children, are of the opinion that a careful health appraisal should be made of children on entrance to school and periodically thereafter. It is their belief that the physician should play the principal role in this appraisal and that the physician of choice is the one who normally serves the particular child and his family.

The health appraisal should be something less than a pediatric examination, but something more than a hurried inspection of the tonsils and a pat on the head. It is, first, an educational experience for the child and parent and, second, an evaluation of the child's development and fitness to undergo the intellectual, emotional and social changes incident to starting school. To be sure, the physician will look and listen and record his observations and make recommendations that will lead to diagnosis and treatment, if he suspects the presence of illness or defect that will interfere with the educational process. He may even follow up his observations to insure correction if correction is feasible. But more important is his relation to the child.

Starting school is a critical time for the child, his first great venture away from home, a division of allegiance and an exposure to a strange new world. He senses that his presence before the doctor is part of his preparation, even though he may not understand the significance of the procedures performed. A chance to talk with the doctor for a moment, the feel of sure hands during the examination and the assurance that he has been found fit for

his new mission are likely to raise the doctor in his estimation. Here, even more than during his baby years, he begins to feel that he is a part of the community to which the doctor belongs and to be called acceptable by the doctor puts that doctor, and doctors in general, in a very special category. "My friend the doctor" has real meaning, if the doctor has been friendly and helpful. How hollow that phrase can be if the examining physician has been hasty and gruff and obviously irritated that a parent used his time for a well child.

Though the Summer Round-Up Program was started by the Congress of Parents and Teachers to detect defects and lead to their correction, modern thinking in relation to the school health program suggests that the development of an easy, friendly relation between the child and his physician is a more valuable outcome. Every child who learns early the physician's place in his life, and who has been taught in his contacts with his physician that this doctor, any doctor, is his friend, will continue through the years to have an attitude toward the profession that will help solve many of the social problems which now trouble us both individually and collectively.

Many physicians engage in this annual Summer Round-Up with interest. If any consider it a chore, they miss an excellent opportunity to protect child health and advance the public relations of medicine simultaneously.

ENDOCARDITIS FROM HEART STRAIN

The experimental production of endocardial vegetations as a result of increased work load on the heart is reported by Lillehei [1] and associates of the University of Minnesota. In dogs, increased cardiac work load was brought about by large arteriovenous fistulas, such as (*a*) iliac fistula between the iliac artery and vein, (*b*) femoral fistula between the femoral artery and vein or (*c*) aorta-vena cava anastomosis. Most fistulas were 23 to 40 mm. in length. Two fistulas were usually made in each dog by two operations staged one to four weeks apart.

The physiological effect of such fistulas is lowering of peripheral resistance. This is compensated for by a sixfold increase in cardiac output. The mean carotid pressure is not significantly altered, but the pulmonary artery pressure is increased twofold. There is a twofold increase in plasma volume. Most of the dogs with arteriovenous fistulas died or were killed 100 to 300 days after the second operation.

At autopsy, dogs with sufficiently large fistulas invariably showed a twofold increase in the weight of the adrenal glands. Those with single or smaller fistulas usually had adrenal glands of approximately normal weight. The hypertrophied adrenal glands were usually accompanied by well developed endocarditis, with vegetations on both the mural and valvular endocardium. These varied from soft friable vegetations, such as those seen in human bacterial endocarditis, to firm smooth vegetations typical of rheumatic endocarditis. Rupture of one or more valve cusps frequently occurred. In dogs with vegetations, micro-organisms were usually found in the blood. These were usually one of the common pathogens, such as Streptococcus viridans, hemolytic Streptococcus or Aerobacter aerogenes.

Dogs killed early after double fistula occurred, but before the production of endocarditis, usually showed enlarged adrenal glands. This would seem to indicate that adrenal hypertrophy precedes the development of the heart lesion.

1. Lillehei, C. W.; Bobb, J. R. R., and Wisscher, M. B.: Proc. Soc. Exper. Biol. & Med. **75**: 9 (Oct) 1950

EXTRANEURAL POLIOMYELITIS

In 1949, Enders, Weller and Robbins [1] of Harvard University reported suggestive evidence that poliomyelitis virus is able to multiply in tissues other than those of the nervous system. Experiments with tissue cultures were afterward undertaken by them [2] to determine whether the Lansing strain could be propagated in human embryonic tissue cultures. Tissue fragments from the arms, legs, intestines and brain of human embryos of 2 to 4 months and from a premature infant of 7 months were suspended in 3 cc. of a mixture of balanced sodium chloride solution (3 parts) and ox serum ultrafiltrate (1 part). Each tube was inoculated with 0.1 cc. of a 10 per cent suspension of infected mouse brain. Nutrient fluid was removed as completely as possible and replaced at periods ranging from four to seven days. Each subculture was inoculated with 0.1 cc. of centrifuged supernatant fluid from a previous culture.

Comparison by means of the mouse LD_{50} showed that the virus had increased 10^{15}-fold by the end of 67 days in a tissue culture composed of a mixture of skin, muscle and connective tissue of a human embryo. In a parallel test with embryonic intestine, the calculated increase was about 10^{13}-fold. They stated that multiplication of the Lansing strain in tissues which do not contain intact neurons is evidence that virus proliferation had occurred either in peripheral nerve endings or in cells not of nervous origin.

The Harvard investigators afterward sought to decide between these two alternatives by histological and physiological means. They found that, over a period of 30 days, fragments from control tissue cultures showed numerous normal-appearing and well stained cells. In parallel tubes infected with either the Lansing or the Brunhilde strain of poliomyelitis virus, few, if any, normal cells were noted, loss of typical staining properties, nuclear pyknosis and fragmentation of cells being dominant. Tissue fragments in which poliomyelitis virus has been propagated fail to show migration and peripheral growth of cells noted in control cultures. This loss of growth potential can be prevented by the use of type-specific antiserum. Control tubes show a relatively rapid metabolic rate, as measured by a fairly rapid decrease in the pH of the supernatant fluid. Little or no decrease is noted in the virus-infected tubes. The Harvard investigators believe that this evidence leaves no doubt that poliomyelitis virus can multiply in cells other than those of the nervous system and cause profound injury to extraneural cells.

1. Enders, J. F.; Weller, T. H., and Robbins, F. C.: Science, **109**: 85, 1949.
2. Robbins, F. C.; Enders, J. F., and Weller, T. H.: Proc. Soc. Exper. Biol. & Med. **75**: 370 (Nov.) 1950.

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THE PRESIDENT'S PAGE

A MONTHLY MESSAGE

"I am an American, a free American: free to speak without fear; free to worship God in my own way; free to stand for what I think right; free to oppose what I believe wrong; free to choose those who govern my country."

This hallowed and inspiring freedom pledge carries a much fuller meaning for me now since my return from a three week trip to the Far East. I was one of six civilian consultants to serve on a mission for Major Gen. Harry G. Armstrong, Surgeon General of the U. S. Air Force, who is carrying on a prodigious and breath-taking job on many fronts with skill and intelligence. The high caliber of the work he is directing is well recognized by all who have the occasion to view it. Accompanying us on the trip, besides General Armstrong, were a number of staff officers from his headquarters and several officers of the School of Aviation Medicine.

Considering the fact that the U. S. Air Force is a comparatively new and separate entity in the defense setup, a great deal of progress has been made in providing the best medical care to our fighting airmen. On April 1, we attended a simple ceremony, marking the transfer of three big hospitals in Japan from the Army to the Air Force, indicating the rapid and efficient changeover which is taking place.

The six civilian consultants, who made the trip were Dr. Cortez F. Enloe, internist from Manhasset, L. I., N. Y.; Dr. William P. Holbrook, internist, Tucson, Ariz., president of the American Rheumatism Association; Dr. Russell V. Lee, internist and director of the Palo Alto, Calif., Clinic; Dr. John M. Murray, professor of clinical psychiatry at Boston University; Dr. Herbert B. Wright, chief surgeon at St. Vincent's hospital, Cleveland, and chief urologist, Deaconess hospital, Cleveland, and myself. Dr. Enloe is a consultant, and Dr. Wright a member of the A. M. A. Council on National Emergency Medical Service. They investigated the civil defense setup in Japan and informed me later that they gained a wealth of material that will be helpful to the Council in studying civil defense plans in this country.

The six of us visited the Travis, Calif., Air Base hospital, where evacuees are brought in from the Far East fighting fronts; Hickam Air Force Base in Hawaii; The Army Tipler Hospital in Hawaii, which is jointly staffed by the Air Force, Army and Navy; Guam; Clark Field in the Philippines; Okinawa; Nagoya, Japan; Tokyo; Kimpo, Munsan and Chunchon in Korea, where we witnessed the effects of some intense and bloody fighting. We also visited our medical installations in Alaska on our return trip.

I considered myself very fortunate in being allowed to board one of the air evacuation aircraft, loaded with the wounded and the sick, for the trip from Taegu, Korea, to Tokyo. I talked to many of the wounded, and all of them were outspoken in their praise of the medical treatment they were receiving.

One soldier, a Negro lieutenant, told me: "Doctor, I was wounded when a mortar blew up. I was taken to a first aid station in five minutes, and within 55 minutes I was on a plane heading for a hospital. When they take care of you like that, a man doesn't mind fighting."

While in Tokyo, I visited the Tokyo General Hospital, a wonderfully operated, 1,200 bed Army institution. I also had the pleasure of chatting with many of my medical officer friends in the Far East. We saw the exceptionally fine work being done by Col. Clyde Brothers, Air Force surgeon in the Far East, and also by Major Gen. Edgar E. Hume, chief surgeon, and Brig. Gen. Crawford F. Sams, chief of the public health and welfare section, general headquarters, Supreme Commander for the Allied Forces. It was a great pleasure, too, to talk with Major Gen. Raymond W. Bliss, Army Surgeon General, who was in Tokyo at the time, and with Gen. J. S. Simmons, Dean of the Harvard School of Public Health, who was called back into service on a special mission.

One thing that impressed me was that none of the Far East hospitals is overstaffed as they were during the last war. I talked with many, many doctors, and all of them feel that they are doing a worth while job. It was plainly evident to all of us that the situation, so far as medical personnel morale is concerned, is much improved over what it was during Pacific fighting in World War II. It is apparent, too, that there is no waste of medical manpower.

The record of air evacuation during the Korean war is one of the brightest chapters in the history of our Air Force. When the Communists first launched their drive southward, the Fifth Air Force was staffed with only enough personnel to handle normal peacetime, intratheater evacuations. The air crews and air evacuation nurses and technicians flew as many as three round trips a day to Korea from Japan during the early days of the war. Their hours were long—with little or no rest for anyone. They literally worked themselves to the point of exhaustion.

It is to the undying credit of the officers and airmen who participated during this period that, despite fatigue, bad flying weather, and the danger of enemy gunfire and bombing, not one single flight was refused. There are many American soldiers who owe their lives to the courage of these people, who expected no other reward. Although one flight nurse and two medical technicians lost their lives in a crash while proceeding to Korea, not one patient was lost due to an aircraft accident. While the shortage of personnel is now a thing of the past, the fine work of the air evacuation personnel continues.

The mortality rate for wounded American soldiers has been cut from about four per 100 injured men who reached hospital installations during the second World War to two men per 100 so far during the Korean conflict. In the first World War the mortality rate for the injured was eight out of 100. Speedy air evacuation is one of the three major reasons for the low mortality rate. The other two are the powerful antibiotics and the more efficient treatment with whole blood and its derivatives.

Since the beginning of the Korean incident, more than 20,000 patients have been flown from the Far East to the United States. A nonstop Tokyo-to-Hawaii air evacuation flight takes only 13 hours. Most of the patients eventually go to hospitals near their homes. West Coast patients are flown from Hawaii straight to Travis Air Force

Base in California. Ninety-five per cent of all evacuations during the Korean war have been by air. Planes carry cargo into the war zones and carry patients back.

Helicopters of the Air Force 3rd air rescue squadron are doing a great job in swiftly removing the wounded and injured from the battle areas in Korea. We were told that these helicopters have evacuated nearly 1,400 patients since the fighting started, often under intense enemy fire and adverse weather conditions. In a recent mission the helicopters removed 56 men from a battle line area. A case was brought to our attention in which a soldier, shot in both the arms and legs, was removed by helicopter from a position 30 miles behind the enemy lines. He was in the Tokyo General Hospital less than 23 hours later.

The most serious health hazards faced by our soldiers in Korea during the warm weather months are insect-borne diseases, including malaria and Japanese "B" encephalitis. Wide scale aerial dusting and spraying operations are the answer. Effective spraying is done by pilots especially trained for this work.

The thing that impressed me most and touched my heart deeply was the great heroic sacrifices that are being made by our fighting men—pilots, foot soldiers, doctors, nurses, sailors—in fact, men and women in every branch of the services. From the things we saw we could not help admiring the courage everyone possesses along our fighting fronts—on land, at sea and in the air. One has the feeling that our fighting men are under a sort of suspended death sentence without knowing when the reprieve will be canceled. While they are waiting, they go on living and joking and eating. We want to know what they are thinking, but you cannot seem to get up the courage to ask them, and probably they could not tell you anyway. Their actions and unspoken thoughts gave all of us a new sense of value in preserving and protecting the priceless blessing of freedom for ourselves and for the generations to come.

A.M.A. President Elmer L. Henderson, Louisville, just back from an Air Force mission in the Far East, is shown engaging a wounded doughboy in conversation while aboard a U. S. Air Force C-54 Skymaster of the 374th Troop Carrier Wing on a Korean air evacuation mission. Dr. Henderson accompanied Major Gen. Harry G. Armstrong's party on a tour of Air Force medical facilities.

One of the happiest moments during our entire trip came when General Armstrong and I received a personal invitation from General MacArthur, then supreme commander of the United Nations Forces in the Far East, to visit him at his headquarters in Tokyo. We talked about many things for more than an hour, and when we shook hands at our departure, I recalled the words once uttered by a military man in history: "He is chewing a big slice of bread with damn little butter."

ELMER L. HENDERSON, M.D.,
Louisville, Ky.

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ORGANIZATION SECTION

SERVICE FELLOWSHIP FOR COMMISSIONED OFFICERS

There has been some question among medical officers in the Armed Forces concerning their eligibility for Service Fellowship in the American Medical Association. This classification of Fellowship is given to commissioned medical officers of the United States Army, United States Navy, United States Air Force and the United States Public Health Service who have been nominated by the Surgeons General of the respective services (and the permanent medical officers of the Veterans Administration) after approval by the Judicial Council. *Service Fellowship is available to those commissioned medical officers of the Armed Forces who are in the regular service only.* Their names are automatically selected from a roster of medical department officers made available to the Directory Department of the American Medical Association every three months by the Armed Forces.

MEDICAL LEGISLATION

FEDERAL

Air Pollution

Two bills have been introduced which would provide research into the health hazards of air pollution. Representative Corbett of Pennsylvania introduced H. R. 3536, and Representative Denny of Pennsylvania introduced H. R. 3538. Both bills are identical and would authorize and direct the Surgeon General of the Public Health Service to conduct investigations and research into health hazards of air pollution, and to develop preventive and control measures. The program would continue in effect for three years. There would be authorized an appropriation of $500,000 for the first year and such sums as are necessary thereafter.

Physically Handicapped

Four identical bills have been introduced in the House of Representatives proposing the establishment of a federal agency for the handicapped. H. R. 3559 was introduced by Representative McCormack of Massachusetts, H. R. 3560 by Representative Shafer of Michigan, H. R. 3581 by Representative Hagan of Minnesota and H. R. 3640 by Representative Celler of New York.

These bills were introduced at the request of the American Federation of Physically Handicapped. They would establish the agency with independent agency status; however, it would be based in the Department of Labor for "housekeeping" purposes. The present Office of Vocational Rehabilitation located in the Federal Security Agency would be abolished and its functions transferred to the new agency. The following new programs would be included: 1. A research program carried out under the direction of an interagency committee—members from the Bureau of Labor Standards, Labor Statistics, Employment Security, Apprenticeships, the Civil Service Commission, Social Security Administration, the Public Health Service, the Office of Education and the Children's Bureau. 2. A program for lending money on the recommendation of state agencies to persons, organizations and governmental agencies interested in rehabilitation of handicapped persons. 3. A program for assistance to states for pensions ($60 monthly) to needy totally disabled persons whose rehabilitation is unfeasible. (Title IV of the Social Security Act now provides similar benefits.) 4. Assistance to state programs providing grants for training homebound handicapped persons. 5. Provision for cooperation with the Civil Service Commission and the U. S. Employment Service to facilitate the hiring of handicapped persons. 6. Provision for cooperation with federal agencies, the American Institute of Architects, Bureau of Labor Standards and others in the promotion of public safety programs. 7. Several programs for the severely handicapped—assisting state programs which provide services to sheltered workshops, assistance to home-bound handicapped persons and establishment of business enterprise programs for the handicapped. 8. Assistance to state programs in the maintenance of rehabilitation centers. Many of these new programs are also included in S. 1202, previously reported in THE JOURNAL.

The summary of federal legislation was prepared by the Washington Office of the American Medical Association and the summary of state legislation by the Bureau of Legal Medicine and Legislation.

STATE

Florida

Bills Introduced.—H. 3, proposes regulations for the employment of **county medical examiners** and sets forth the duties of such medical examiners and the circumstances under which autopsies would be permitted. H. 8, proposes the enactment of a **physical therapist practice act** and defines physical therapy as the treatment of disability, injury and disease by non-medical means comprising the use of massage, therapeutic exercises, and the physical, chemical, and other properties of heat, light, water, and electricity (except roentgen rays, radium, and electrosurgery). H. 150, proposes that any doctor or other practitioner of any of the healing sciences making a physical or mental examination or treatment of any person shall, on request of such person, his guardian, curator or personal representative in the event of his death, furnish copies of all **reports made of such examination or treatment.** Such reports would not be furnished to any person other than the patient, his guardian, curator, or personal representative, except on the written authorization of the patient. H. 193, proposes amendments to the **chiropractic act** relating to the grounds for revocation of the license. One ground is that the licentiate permits persons not licensed to practice chiropractic in the state to set up in his office what is commonly called and termed "traveling clinics" and permits these unlicensed persons to practice chiropractic under color of the licentiate's license or to counsel or advise persons concerning the cure or treatment of any disease or bodily ailment. S. 71, proposes that in order to induce the establishment of an accredited medical school in the state, the state shall pay to the first accredited and **approved medical school** the sum of $3,000 per year for each student admitted and enrolled in such institution, under certain circumstances. S. 80, to amend the **medical practice act,** would require applicants for admission to examination to submit evidence that, if they are not graduates of a medical school or college approved by the board, they have received training, subsequent to graduation from medical school or college, in hospitals whose standards and reputability are approved by the board, sufficient to bring their medical education up to a standard equivalent to that of graduates of approved medical schools and colleges. S. 81, to amend the **medical practice act,** proposes among other things to authorize the examining board to delegate one or more of its members, or any other duly qualified person, the power and authority to make an investigation of medical schools for the board and to report their conclusions. The board, if satisfied with the correctness of the investigation, may also adopt inspections of medical schools, colleges and hospitals made by or under the authority of the American Medical Association or other nationwide groups. S. 82, to amend the **medical practice act,** proposes to increase the license fee from $25 to $50. S. 85, proposes that a certificate by one of the examining boards certifying that the records of such board evidence, or fail to evidence, the issue of a license or other **authority to practice** the particular profession to a named person shall be prima facie evidence of such fact and of the authority, or want of authority, of such person to practice such profession in the state. S. 86, proposes to authorize the **state board of medical examiners** to appoint or employ an assistant secretary or secretaries who need not be physicians or members of the board.

Illinois

Bills Introduced.—SJR 25, proposes to request the Board of Trustees of the University of Illinois to amend the rules governing the College of Medicine in order to provide for the annual admission of at least 20 students who will agree to practice in the **rural areas** of the state. S. 396, proposes to authorize the Department of Public Health to establish and maintain a **Bureau of Industrial Hygiene** and sets forth the duties of such bureau.

Minnesota

Bills Introduced.—H. 1569, proposes the appointment of a commission to make a study relating to workmen's compensation laws in the state. H. 1699, proposes to authorize a probate judge to direct a sheriff to take into custody and confine for observation and examination persons alleged to be **mentally ill.** H. 1719, proposes to authorize cities having a popula-

tion of less than 100,000 to levy an occupational tax upon professions serving the local populous. S. 1376, proposes a law for the licensing of **physio-therapists** and defines physical therapy as the treatment of any bodily or mental disorder of any person by the use of the physical, chemical and other properties of heat or cold, light, electricity, massage, mechanical devices and therapeutic exercise which includes posture and rehabilitation procedures provided, however, the use of roentgen rays and radium for diagnostic and therapeutic purposes and the use of electricity for surgical purposes including cauterization are not authorized under the terms of the proposal. A physical therapist would be a person who practices physical therapy under the prescription and direct supervision of a person licensed and registered in the state to practice medicine and surgery. S. 1503, proposes to define the term **"vendor of medical care,"** so far as the director of social welfare is concerned, as encompassing any person who furnishes any or all of the following goods or services: medical, surgical, hospital, optical, dental, nursing services, drugs and medical supplies, appliances, laboratory, diagnostic and therapeutic services, nursing home and convalescent care and such other medical services or supplies provided or prescribed by persons authorized by state law to give such services and supplies.

Bill Enacted.—S. 901, has become Resolution Chapter 5 of the Laws of 1951. It provides that the Congress of the United States be requested to immediately re-enact into law the **emergency maternity care** program for the benefit of pregnant wives of men serving in the armed forces of the United States during the present national emergency.

Nevada

Bills Enacted.—A. 57, has become Chapter 178 of the Laws of 1951. It amends the **chiropractic act** by providing for the licensing of persons desiring to practice chiropractic physio-therapy which is defined to be the adjustment of the articulations of the human body by hand and the use of electrical, mechanical, hygienic and sanitary measures, which measures do not pierce or sever the body tissue. A. 124, has become Chapter 336 of the Laws of 1951. It is a licensing law for the **regulation of hospitals,** nursing and maternity homes by the State Department of Health. A. 130, has become Chapter 124 of the Laws of 1951. It authorizes the Board of Medical Examiners to issue **temporary or limited permits** granting applicants the right to serve as resident medical officers in any hospital in the state. Such permits would not permit the holder to engage in the private practice of medicine, surgery or obstetrics in Nevada. S. 55, has become Chapter 332 of the Laws of 1951. It is a **basic science act** which requires all persons, before taking an examination for a license to practice the healing art or any branch thereof, to present to the board or officer empowered to issue such license a certificate of ability in anatomy, physiology, chemistry, bacteriology and pathology issued by the state board of examiners in the basic sciences. The "healing art" includes any system, treatment, operation, diagnosis, prescription or practice for the ascertainment, cure, relief, palliation, adjustment or correction of any human disease, ailment, deformity, injury or unhealthy or abnormal physical or mental condition.

New Hampshire

Bills Enacted.—H. 81, has become Chapter 26 of the Laws of 1951. It provides a licensing law for persons desiring to practice as licensed **practical nurses** and to use the title licensed practical nurse. H. 274, has become Chapter 56 of the Laws of 1951. It provides that an applicant for a license to practice **chiropractic** who matriculated in a chiropractic school or college after January 1, 1951 shall be a graduate of a legally chartered or incorporated school of chiropractic requiring for a graduation completion of a course of study of not less than thirty-six hundred class-room hours in four academic years. S. 13, was approved March 20, 1951. It authorizes the Board of Registration in medicine to register **physical therapists,** under certain circumstances. Physical therapy is defined to mean the treatment of any bodily or mental condition of any person by the use of the physical, chemical and other properties of heat, light, water, electricity, massage and therapeutic exercise, which includes physical rehabilitation procedures. The use of roentgen rays and radium for diagnostic and therapeutic purposes and the use of electricity for surgical purposes, including cauterization, are not authorized under this act. A person who is not registered under this act may not use the words or letters "R.P.T." "Registered Physical Therapist." A person who is registered under the act as a physical therapist shall not treat human ailments by physical therapy or otherwise except under the prescription, supervision and direction of a person licensed to practice medicine and surgery.

North Carolina

Bills Introduced.—H. 561, proposes the creation of a **commission on postmortem medicolegal examinations and investigations.** This commission would appoint a chief medical examiner and investigator for the state who shall be a licensed doctor of medicine and a skilled pathologist holding the certificate of the American Board of Pathology in pathologic anatomy. The proposal then provides for the appointment of district pathologists and county medical examiners and investigators and sets forth the situations in which autopsies and other pathological examinations of deceased persons may be performed. H. 576, proposes the appointment of a state commission of **naturopathic examiners** and defines naturopathy as a system of physical culture advocating and employing scientific, dietary control and drugless treatment of disease, stimulating or assisting nature by using physical forces, aided by manual, mechanical and electrical devices or appliances; provided that nothing shall be held or construed to authorize any naturopathic physician licensed under this proposal to practice materia medica or surgery. H. 600, proposes that the reports and certificates of death in all matters pertaining to public health made by **chiropractors** shall be accepted by the officers or departments to which the same are made. H. 768, proposes to make it mandatory for the Board of County Commissioners of Clay County to levy a sum of money for a **public health program** in the county. H. 892, proposes to authorize charitable non-profit corporation operating **charitable hospitals,** under rules, regulations and procedures to purchase hospital supplies and equipment under contracts negotiated and entered into by the division of purchase and contract for the purchase of hospital supplies and equipment for state hospitals and other institutions of the state. H. 913, proposes regulations for the practice of physical therapy by **registered physical therapists.** S. 304, proposes than any person who may otherwise validly make a will may, by will, **dispose of the whole or any part of his or her body** to a teaching institution, university, college, state department of health, legally licensed hospital or any other legally licensed hospital, agency or commission operating an eye bank, bone or cartilage bank, a blood bank or any other bank of a similar nature and kind designated for the rehabilitation of the maimed. S. 310, proposes that when it shall appear to the medical staff of a state institution that a patient is in need of some type of surgical operation for the preservation or restoration of health and no responsible relative can be located, the medical superintendent or the director of the institution, the surgical consultant, and the local health officer of the county in which the hospital or institution is located shall constitute a board to pass upon the physical condition of the patient and may by unanimous agreement authorize the **necessary surgical operation,** including the administration of an anesthetic.

Ohio

Bill Introduced.—S. 67, proposes regulations for the registration by the board of health of **public health sanitarians** who are defined as persons trained in the field of public health sanitary science and public health sanitary technology and are qualified to carry out educational, consultative, administrative and inspectional duties and to enforce the law in the field of public health sanitation.

Bill Enacted.—H. R. 38, was adopted Feb. 7, 1951. It provides for the creation of a committee to make any inquiries and investigation into any and all matters pertaining to any of the **state examining boards.**

Pennsylvania

Bills Introduced.—H. 728, proposes to permit the necessary **visual examination of school children** to be performed by opthalmologists or optometrists. H. 828, proposes the enactment of a **practical nurse law** for the licensing and examining of practical nurses. H. 869, proposes that each member of the **Board of Chiropractic Examiners** shall, at the time of his appointment, be licensed and qualified under the laws of the state to practice chiropractic. H. 933, proposes that every employer employing one hundred or more persons in any shop or factory shall employ or engage one or more **licensed physicians** who shall be present to render medical assistance at all necessary times at the place where work is in progress. H. 951, proposes that the testimony of an **optometrist** who is licensed to practice optometry shall be received by any official board, commission or agency of the Commonwealth or its political sub-divisions as qualified evidence and that such agencies shall not discriminate between the practitioners of optometry and any other ocular practitioners. S. 145, proposes an appropriation to the Jefferson Medical College for the maintenance and support of an **institute of geriatrics.** S. 147, proposes an appropriation for the general maintenance of the **Jefferson Medical College.** S. 349, proposes the establishment of a **scholarship plan for the medical education** of qualified residents of the commonwealth. Among other things, an applicant who accepts a scholarship under this plan must agree to serve in any state institution designated by the Secretary of Welfare as an intern or resident for a period of not less than four years after his graduation from medical school. S. 421, proposes an appropriation to the School of Medicine of Temple University for the maintenance and equipment of an Institute for Research into the Causes or Cause of **Cancer** and its Diagnosis, Prevention and Treatment. S. 424, proposes regulations for the licensing by the Department of Health of institutions desiring the **use of live dogs and cats** for the effective carrying on of their scientific or educational activities. S. 455, proposes an appropriation to the Department of Health for the operation and maintenance of the Institute for Cancer Research, Incorporated.

Bills Enacted.—H. 331, was approved April 6, 1951. It **defines the word medical examiner** in connection with private and parochial school examinations as including licensed physicians qualified to practice medicine and surgery or osteopathy or osteopathic surgery. H. 332, was approved April 6, 1951. It **defines the word physician** as an individual licensed under the laws of the state to engage in the practice of medicine and surgery or in the practice of osteopathy or osteopathic surgery.

West Virginia

Bills Enacted.—H. 233, approved March 15, 1951. It provides, among other things, that hospital and **medical non-profit corporations** must provide, in their contracts, that in case of a deficit of available funds, each participating hospital or physician will accept a pro rata share of available funds in full settlement of any bill submitted. H. 248, was approved March 16, 1951. It amends the medical practice act by admitting to the examination a person who shall have graduated from a medical school on or after Jan. 1, 1939 and who meets all the requirements of the law pertaining to education and training except that the medical school was not at the time of graduation a **class A medical school** as defined by statute. H. 477, was approved March 16, 1951. It authorizes the Board of Governors to establish and maintain in the University a **four-year school of medicine,** dentistry and nursing.

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MEDICAL NEWS

ARIZONA

State Medical Meeting at Tucson.—The Arizona Medical Association will hold its annual meeting April 29-30 at the Pioneer Hotel in Tucson, under the presidency of Dr. Robert E. Hastings, Tucson. Invited speakers include:

John Van Prohaska, Chicago, Physiology of Gastric Secretion and Its Relation to the Surgical Treatment of Peptic Ulcer.
Edward B. Tuohy, Washington, D. C., Anesthesiology and Its Practical Adaptation into General Medicine and Surgery.
Edmund L. Keeney, San Diego, Calif., Medical Fungi, The Infections and the Allergies That They Provoke.
John S. Chapman, Dallas, Texas, Unusual Varieties of Pneumonia and Abscess.
Otto Stein Brocker, New York, ACTH and Cortisone in the Management of Rheumatoid Arthritis.
Donald L. Paulson, Dallas, Texas, Surgical Treatment of Esophageal Lesions.
Kenneth C. Sawyer, Denver, Surgical Treatment of Carcinoma of the Skin.

Several state specialty societies will meet Monday afternoon. The President's Dinner Dance will be held at 7:30 p. m. Tuesday. The Woman's Auxiliary will also have its headquarters at the Pioneer Hotel.

CALIFORNIA

Narcotic Violation.—Dr. Jens P. Jensen, Manx Hotel, San Francisco, pleaded guilty to a violation of the California State narcotic law. On March 6 he was fined $100 and placed on probation for a period of one year.

State Medical Meeting at Los Angeles.—The California Medical Association will convene in annual session May 13-16 at the Biltmore Hotel in Los Angeles, under the presidency of Dr. Donald Cass, Los Angeles. Guest speakers at the general sessions include:

Charles G. Heyd, New York, The Nongroup Subscriber: A Blue Shield Problem.
Cyrus C. Sturgis, Ann Arbor, Mich., Treatment of Anemias.
Herbert C. Maier, New York, Advances in Thoracic Surgery.

Section meetings will be held Monday, Tuesday and Wednesday. A motion picture program has been planned for the entire session. The Woman's Auxiliary will have its headquarters at the Biltmore Hotel, where it is meeting May 13-15. Preconvention conferences, sponsored by the association's Cancer Commission, will be held at the Biltmore Hotel on Saturday preceding the association meeting. A conference on microscopic tumor pathology, meeting from 9:30 a. m. to 4:30 p. m., will be under the chairmanship of Dr. James E. Kahler, Los Angeles. Members are requested to bring their own microscopes. A conference on radiology, meeting all day Saturday at the Biltmore Hotel, will be under the chairmanship of Dr. Ralph F. Niehaus, San Diego.

IDAHO

State Appointments.—Governor Len Jordan has appointed two physicians to the State Board of Medicine for six year terms. Reappointed was Dr. Warren B. Ross of Nampa. Dr. Reed J. Rich of Montpelier was appointed for a similar term and succeeds Dr. Harwood L. Stowe of Twin Falls. Dr. Russell T. Scott, Lewiston, has been appointed by the governor as a member of the Hospital Advisory Council to the state department of public health for a six year term. Dr. Hubert E. Bonebrake of Wallace is also a member of the council. All members of the State Board of Eugenics have been reappointed: Dr. Edwin P. Peterson, Boise; Dr. Joseph W. Marshall, Twin Falls; Dr. Erhard R. W. Fox, Coeur d'Alene; Dr. Kenneth H. Collins, Craigmont, and Dr. John W. Wurster, Pocatello.

Physicians are invited to send to this department items of news of general interest, for example, those relating to society activities, new hospitals, education and public health. Programs should be received at least three weeks before the date of meeting.

ILLINOIS

Rabies in Illinois.—Last year 3,258 residents of the state were given the Pasteur antirabic treatments after exposure to the disease, according to the *Chicago Tribune*. There were no deaths. As of March 20, two townships were under rabies quarantine, one in Clinton County and the other in Pike County. More than 220 animals among those who had bitten 14,692 Illinois residents were proven to be rabies carriers. They included 111 dogs, 45 cats, 31 cattle and several horses, swine, foxes, squirrels, skunks and raccoons. The disease is estimated to cost Illinois farmers $500,000 annually in loss of live stock and live stock products. L. R. Davenport, D. V. M., chief of the section on veterinary public health of the state public health department, says that to this number must be added the unreported outbreaks among wild animals and in dogs or other domestic animals.

Chicago

The MacEachern Fund.—The Malcolm T. MacEachern Fund for the Advancement of Training of Hospital Administrators was formed in December at Northwestern University to insure continuance of the hospital administration course in the university, for which $250,000 will be raised in five years. Dr. MacEachern is professor and director of the university's hospital administration program.

KENTUCKY

General Practitioners Award.—The Academy of General Practice of Kentucky is offering an award for the best paper submitted on any subject pertaining to general practice. Any general practitioner in the state may submit a paper on original work he has done as a general practitioner. The paper is to be typewritten, double spaced and should bear no name. A sealed envelope containing the name and address of the physician writer should be clipped to the manuscript. Papers must be submitted before July to the academy office in Morgantown.

MARYLAND

Medical and Surgical Symposium.—The Medical Association of the Lutheran Hospital of Maryland, Baltimore, will present its annual Medical and Surgical Symposium at the hospital May 5 beginning at 9:30 a. m. The speakers will be:

Clarence C. Briscoe, Philadelphia, Changing Concepts in the Management of Abortions.
Harley E. Cluxton Jr., Chicago, Present Knowledge of ACTH and Cortisone.
Richard B. Cattell, Boston, Surgical Aspects of Thyroid Diseases.
R. Philip Custer, Philadelphia, Variants of Chronic Granulocytic Leukemia.

MASSACHUSETTS

Proctology Program.—The proctology staff of the Boston Dispensary has planned an all day program to be held at the Hotel Kenmore in Boston May 5. The program includes:

Lewis S. Pilcher, Newton, Fluid Balance and Electrolytes.
H. Edward MacMahon, Boston, Proctologic Pathology.
Orvar Swenson, Boston, Surgical Treatment of Hirschsprung's Disease.
C. Stuart Welch, Boston, Adaptation of Swenson's Pull-Through Operation for Cancer of the Rectum.
Richard Schatzke, Cambridge, Radiology as an Aid to Proctology.
Fernando Biguria, Boston, Functions of the Colon and Their Alteration in Pathologic States.
Rudolph V. Gorsch, New York, Surgical Anatomy of Perineo-Pelvic Spaces.
David Rose, Cambridge, Mass., Gynecologic Problems in Proctology.
E. Parker Hayden, Boston, Survey of Personal Experiences with Radical Resections for Cancer of the Large Bowel.
Frank H. Lahey, Boston, Present Concepts in Surgical Management of Cancer of the Rectum.
Allan Wilkinson, Boston, Ulcerative Lesions of the Rectum and Lower Colon, Diagnosis and Management.

The guest speaker at the banquet will be Dr. Neil W. Swinton, surgeon at the Lahey Clinic and New England Baptist and Deaconess hospitals.

NEBRASKA

University Appointment.—Dr. Robert H. Dickinson, Chicago, has been appointed a full time associate in neurology and psychiatry at the University of Nebraska College of Medicine, Omaha, where he will be director of the outpatient service at the Nebraska Psychiatric Unit. He is a graduate of the college of medicine and had his psychiatric training at Michael Reese Hospital in Chicago and the Chicago Institute for Psychoanalysis.

NEW MEXICO

State Medical Meeting in Santa Fe.—The annual session of the New Mexico Medical Society will be held in Santa Fe May 3-5 under the presidency of Dr. Ira J. Marshall of Roswell. Scientific sessions will be held in the morning and afternoon, with roundtable luncheon discussions during the noon hour. A feature of the program will be a symposium on Medical Aspects of the Atomic Bomb and Radiation Injuries. Guest speakers, according to the preliminary program, include: Drs. Owen H. Wangensteen, professor of surgery, University of Minnesota Medical School, Minneapolis; George C. Griffith, professor of medicine, and Marcy L. Sussman, clinical professor of radiology, University of Southern California School of Medicine, Los Angeles; Howard B. Sprague, Harvard Medical School, Boston, president of the American Heart Association, and William R. Oakes, Los Alamos Medical Center, Los Alamos, N. Mex. The morning and afternoon scientific programs and discussions on Saturday will be symposiums on modern medical, surgical and radiological aspects of cardiac diseases. The state Academy of General Practice and Trudeau Society will hold luncheon meetings. The Woman's Auxiliary will meet May 3-4.

NEW YORK

Hospital News.—Dr. Edward G. Waters, Margaret Hague Maternity Hospital, Jersey City, N. J., spoke at St. Joseph's Hospital, Yonkers, April 11 on "Surgical Complications of Pregnancy."——On alumni day, May 6, at the Brooklyn Jewish Hospital the following program will be presented at 3:00 p. m. in the Louria Auditorium.

Bernard S. Epstein, Brooklyn, Roentgenologic Aspects of Intracranial Disease, discussed by Benjamin Kramer, Brooklyn, and I. Max Tarlov, New York.

Alexander S. Wiener, Brooklyn, Some Immunological Aspects of the Blood Groups and Their Implications for Clinical Medicine, discussed by Silik H. Polayes, Brooklyn.

Sidney E. Lenke, Brooklyn, Electrophoresis as a Clinical Tool, discussed by Albert E. Sobel.

Isaac W. Karlin, Brooklyn, Diagnosis and Treatment of Stuttering, discussed by Doris H. Milman, Brooklyn.

New York City

Fraternity Lecture.—Phi Epsilon Delta, medical fraternity at Cornell Medical College, is sponsoring a lecture by Homer W. Smith, Sc.D., professor of physiology at New York University College of Medicine, who will talk on "Recent Developments in Renal Function" May 11 at 8: 30 p. m. in the Cornell Medical College Auditorium.

Society News.—Dr. Sam Parker has been elected president of the Brooklyn Psychiatric Society. Other officers include Dr. Joseph L. Abramson, vice president, and Dr. Morton H. Hand, secretary-treasurer.——Dr. Joseph H. Globus will read a paper entitled "Neurologic Disorders of Interest to the Oral Surgeon" at the monthly conference of the New York Institute of Clinical Oral Pathology April 30 at the New York Academy of Medicine at 9:00 p. m.

Meeting on Radiation Therapy.—The Bellevue Hospital Radiation Therapy Alumni Association will hold its annual meeting May 10 at 1: 30 p. m. The annual Ira I. Kaplan Lecture will be delivered by Dr. Arthur Purdy Stout, professor of surgery at Columbia University College of Physicians and Surgeons, and it will be discussed by Dr. John F. Daly, professor of otorhinolaryngology, New York University-Bellevue Medical Center, and Dr. William Harris, radiotherapist at Mount Sinai Hospital, New York. The subject is "Mucosal Cancer of the Larynx." The lecture will be followed by a clinic on radiotherapeutic problems.

NORTH CAROLINA

State Medical Meeting at Pinehurst.—The Medical Society of the State of North Carolina will hold its annual meeting at the Carolina in Pinehurst May 7-9, under the presidency of Dr. Roscoe D. Mc Millan, Red Springs. Out-of-state speakers include:

Frank E. Wilson, Washington, D. C., Legislative and Military Influence on Medicine at the National Level.

Maurice C. Pincoffs, Baltimore, Maryland's Medical Program for the Indigent.

Mr. Aubrey D. Gates, Little Rock, Ark., Role of Medicine in Rural Health.

Harry H. Gordon, Denver, Problems of Premature Infants.

Elmer L. Henderson, Louisville, Ky., 1951: Medicine's First Year of Grace.

Robert H. Flinn, Washington, D. C., The Physician's Role in Civil Defense.

Robert Fleming, Boston, A Medical Concept of Chronic Alcoholism.

Howard A. Rusk, New York, Medicine, Mobilization and Manpower.

Carl A. Whitaker, Atlanta, Ga., A Doctor's Contribution to the Mental Hygiene of Civilians at War.

Robert P. Barden, Philadelphia, Roentgen Aspects of Abnormal Pulmonary Function.

Philip Thorek, Chicago, Jaundice.

OHIO

Anniversary of Tuberculosis and Health Association.—A celebration marking 50 years' work in tuberculosis and public health by the Ohio Tuberculosis and Health Association will be held during the annual meeting of the National Tuberculosis Association May 16 at the Netherland Plaza Hotel, Cincinnati. The speaker for the anniversary luncheon will be Dr. Herbert R. Edwards, executive director, New York Tuberculosis and Health Association. Guests will include the boards of directors of the National Tuberculosis Association and the Ohio association, and officers of the American and Ohio Trudeau societies. Reservations may be made by writing the association, 1575 Neil Ave., Columbus 1.

OREGON

Lectures in Obstetrics and Pediatrics.—The Oregon State Medical Society and the state board of health are offering to medical societies of the state the annual Extramural Postgraduate Course in obstetrics and pediatrics. An afternoon and an evening session will be held in each of five centers. Two guest speakers will each present one lecture at each session. Physicians of Oregon and of adjacent out-state communities are invited to attend. Guest lecturers for the first week will be Drs. Karl F. Meyer and Hale F. Shirley, both of San Francisco. They will speak at Hillsboro May 7 and on succeeding days at The Dalles, Pendleton, Ontario and Bend. Guest lecturers the second week will be Drs. Herbert E. Coe and Russell R. de Alvarez, Seattle, who will speak beginning May 14 at Klamath Falls and on succeeding days at Medford, Roseburg, Eugene and Salem.

RHODE ISLAND

State Medical Meeting at Providence.—The Rhode Island Medical Society will hold its annual meeting May 9-10 at its library in Providence. Out-of-state speakers include:

W. Russell MacAusland, Boston, Replacement of the Hip by Endoprosthesis, with moving pictures.

George G. Deaver, New York, Rehabilitation of the Hemiplegic Patient.

Mr. W. Alan Richardson, Rutherford, N. J., What's Happening to Private Practice.

Hobart A. Reimann, Philadelphia, The Charles V. Chapin Oration: Periodic Disease.

Edward J. McCormick, Toledo, Ohio, Democracy, Medical Progress and the American Medical Association.

Robert B. O'Connor, Boston, Industry's Challenge to the Medical Profession.

Arthur W. Allen, Boston, Significance of Gastric Ulcer and Cancer of the Stomach.

Clyde Deming, New Haven, Conn., Hormonal Treatment of Genito-Urinary Diseases.

Merill Sosman, Boston, Accuracy and Reliability of the Roentgen Diagnosis.

Capt. John M. Brewster, MC, USN, Philadelphia, Antihistamine Therapy of the Common Upper Respiratory Response to the Virus of the Common Cold and Other Irritants.

John R. Gray, San Jose, Calif., Present Status of Antibiotics and the Future in This Field.

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VIRGINIA

Social and Environmental Medicine.—This new department at the University of Virginia, Charlottesville, will be concerned with instruction and research in public health and preventive medicine and in sociological problems which affect health and medical care. Dr. Robert D. Wright, senior surgeon, U. S. Public Health Service, has been appointed professor and chairman.

University Appointments.—Dr. E. D. Vere Nicoll, chief assistant in the orthopedic and fracture departments, St. Bartholomew's Hospital, University of London, became instructor in orthopedics at the University of Virginia Department of Medicine, Charlottesville, March 1. Dr. Desmond R. H. Gourley has been appointed assistant professor of pharmacology, effective September 1.

Personals.—Dr. Lucius D. Hill III, resident in thoracic surgery, University of Virginia Hospital, Charlottesville, was awarded the John Horsley Memorial Prize at the annual meeting of the Sigma Xi Society in Charlottesville March 6 for his thesis on "Acute Renal Insufficiency and the Role of Potassium with Treatment by Intestinal Lavage."——Dr. Henry B. Mulholland, professor of internal medicine, University of Virginia, Charlottesville, will attend the meeting of the World Health Organization in Geneva, Switzerland, May 7-25.

WEST VIRGINIA

Personals.—Dr. Robert G. Warren of Williamson, assistant Mingo County health officer, has been named by the governor as superintendent of Denmar Sanatorium to succeed Dr. James H. Nelson Jr., who has resigned to engage in general practice in Charleston.——Dr. H. Sinclair Tait, clinical director of Weston State Hospital, has been appointed acting superintendent to succeed Dr. Charles A. Zeller, who resigned a few weeks ago to accept appointment as head of the psychiatric department of the new veterans hospital at Clarksburg.

State Health Conference.—The annual State Health Conference will be held May 10-12 at the Prichard Hotel in Huntington. Visiting speakers will be:

Albert L. Chapman, Washington, D. C., Public Health Aspects of Atomic Warfare.
Henry F. Vaughan, D.P.H., Ann Arbor, Mich., Nonmedical Health Administration in Local Units.
Mark V. Ziegler, Baltimore, Indigent Medical Service Program in a County Health Unit.

On Friday morning there will be a panel discussion on "Medical and Public Health Services in the West Virginia Civil Defense Program," led by Dr. Newman H. Dyer, state director of health, Charleston. There will be section meetings Friday afternoon. The banquet will be held Thursday evening at 7:00 p. m. Formerly a joint meeting of health officers and the West Virginia Public Health Association, the conference this year will for the first time be held in cooperation with the West Virginia State Medical Association and West Virginia University School of Medicine.

WISCONSIN

Wisconsin Anti-Tuberculosis Association.—Dr. Esmond R. Long, editor of the *American Review of Tuberculosis*, will be one of the speakers at the forty-third annual meeting of the Wisconsin Anti-Tuberculosis Association May 7-8 at the Hotel Schroeder in Milwaukee. Dr. Long, who will speak May 7, is director of the Henry Phipps Institute in Philadelphia and director of research for the National Tuberculosis Association. Dr. Arthur R. Zintek of the State Board of Health will lead a panel discussion on routine admission x-rays in general hospitals May 8, and Dr. James M. Foerster, roentgenologist of St. Mary's Hospital, Wausau, and Dr. Daniel E. Dorchester of the Dorchester and Beck Clinic, Sturgeon Bay, will be physician participants. Dr. John Markson of the Veterans Administration regional office in Milwaukee will speak on "Psychological and Emotional Problems of the Tuberculous." Dr. Joseph H. Chivers, Chicago, chairman of the industrial committee of the Illinois State Medical Society, will speak on "Management's Responsibility for Tuberculosis Problems in Industry."

GENERAL

Association of American Physicians.—This association will hold its annual meeting at Chalfonte-Haddon Hall in Atlantic City, N. J., May 1-2, under the presidency of Dr. Alphonse R. Dochez, New York. A series of 35 papers will be presented, and 14 others will be read by title. Dr. C. Sidney Burwell, research professor of clinical medicine at Harvard University, Boston, will speak at the association dinner on Tuesday at 7: 30 p. m.

American Psychoanalytic Association.—This association will meet at the Netherland Plaza Hotel in Cincinnati May 3-6 under the presidency of Dr. Robert P. Knight, Stockbridge, Mass. Panel discussions will begin Saturday morning on Depressive States, The Cultural Factor in Psychoanalytic Treatment, Delinquency, Group Psychotherapeutic Techniques with "Normal" Leaders and Child Analysis. Scientific papers will be presented Friday and Sunday afternoons.

Society for Pediatric Research.—This society will hold its annual meeting at the Hotel Traymore in Atlantic City, N. J., May 2-3, under the presidency of Dr. Harry H. Gordon, Denver. Authors of papers being given by invitation include:

David Gitlin, Boston, Immunochemical Study of the Serum Albumin in the Nephrotic Syndrome; Douglas E. Johnstone, Buffalo, Use of Soy Bean Trypsin Inhibitor in Stoll Trypsin Determinations; Paul R. Patterson, Boston, A Study of the Duodenal Fluid in Infants with Jaundice.

American Laryngological, Rhinological and Otological Society.—This society will hold its annual meeting May 6-8 at the Claridge Hotel in Atlantic City, under the presidency of Dr. Louis H. Clerf of Philadelphia. The program includes a symposium on Carcinoma of the Larynx, the participants being Drs. Francis E. Le Jeune, New Orleans; Henry B. Orton, Newark, N. J.; Juan A. del Regato, Colorado Springs, Colo.; LeRoy A. Schall, Boston, and Gordon B. New, Rochester, Minn. Authors presenting papers by invitation include:

Paluel J. Flagg, New York, Endotracheal Inhalation and Anesthesia.
Luzius Ruedi, Zurich, Switzerland, Therapeutic and Toxic Effects of Streptomycin in Otology.

Urologists Meeting.—The American Urological Association will meet in Chicago at the Palmer House May 21-24 under the presidency of Dr. Thomas D. Moore, Memphis, Tenn. The sixth annual award for research on the male reproductive tract will be presented on Monday morning to John MacLeod, Ph.D., associate professor of anatomy at Cornell University Medical College, New York. He will address the association on "Certain Concepts in Human Male Fertility." The Ramon Guiteras Lecture will be given on Wednesday afternoon by Dr. George E. Wakerlin, professor of physiology at the University of Illinois College of Medicine, on "The Kidney and Hypertension." Medical motion pictures will be shown each morning from 8: 00 to 9: 00 and on Tuesday afternoon from 2: 00-5: 00 in the general assembly hall on the fourth floor.

New Journal, Neurology.—A new journal, *Neurology*, began publication with its January-February issue as the official publication of the American Academy of Neurology. Its editorial scope will include diseases of the nervous system, neuropathology, neurosurgery, neuroanatomy, neuropsychiatry and neurophysiology. Dr. Russell N. De Jong, Ann Arbor, Mich., is editor and Dr. Webb E. Haymaker, Washington, D. C., associate editor. *Neurology* is under the editorial guidance of the academy's board of editors. The first 98 page issue contains 8 scientific articles, sections called "Treatment Review," "Clinical Pathologic Conference" and "Book Reviews," and an editorial page. The journal may be obtained at the U. S. subscription rate of $8 per year, foreign rate $9 per year, from Neurology, 84 South 10th Street, Minneapolis 3.

Estimated Death Rates for 1950.—The total death rate and the infant mortality rate for the United States in 1950 were the lowest in the history of the country, according to the National Office of Vital Statistics. It is estimated that 1,456,000 deaths occurred in 1950. Although this number was slightly

higher than the number of deaths (1,446,000) in 1949, the rate based on population was lower in 1950. The rate for 1950 was 9.6 per 1,000 population, excluding armed forces overseas, as compared with the rate of 9.7 for 1949, the previous low. In the period since 1940 the death rate has decreased 10 per cent. The estimated number of deaths of infants under 1 year of age reported in the United States during 1950 was 103,700; this was 7,500 less than the 1949 total. The estimated infant mortality rate for 1950 was 29.2 per 1,000 live births, as compared with 31.1 for 1949 and 47.0 for 1940.

Armed Forces Committee.—The president of the American Society of Anesthesiologists, Dr. Urban H. Eversole, has appointed a committee to act as a liaison between the ASA and the medical departments of the Army, Navy and Air Force. Dr. Ralph M. Tovell, Hartford, Conn., has been appointed chairman. Other members are Drs. Henry K. Beecher, Boston; Donald E. Hale, Cleveland; Stevens J. Martin, Hartford, Conn., and Edward B. Touhy, Washington, D. C. A questionnaire is being sent by the Armed Forces Committee to every member of the society and to every other doctor doing anesthesia about whom the committee is informed. This questionnaire is to be used to classify anesthesiologists for the benefit of the Armed Services and tends to insure those anesthesiologists called into military service that they will be properly assigned to duties that utilize their special training.

College Health Association.—The American College Health Association will hold its annual meeting May 3-5 at the Edgewater Beach Hotel in Chicago, under the presidency of Dr. Irvin W. Sander, Wayne University, Detroit. For Thursday afternoon panel discussions are planned on administration in college health services. On Friday morning there will be a symposium on Mental Hygiene with Dr. Dana L. Farnsworth of the Massachusetts Institute of Technology, Cambridge, serving as chairman. Speakers will be Drs. Louis Barbato, Denver, and Bryant M. Wedge, Chicago. On Saturday morning Dr. Arnold L. Wagner, Evanston, Ill., will preside at a panel discussion on Specific Ills Limiting Student Performance. The participants will be Drs. Ernest G. McEwen, Meyer Brown and Arthur R. Colewell, all of Evanston, Ill.; Martin Seifert, Wilmette, Ill., and Richard B. Capps and Theron G. Randolph, Chicago. The guest speaker at the luncheon on Friday will be Dr. Raymond B. Allen, president, University of Washington, Seattle.

Rocky Mountain Medical Conference.—This biennial conference of the five Rocky Mountain medical societies will be held at the Shirley-Savoy Hotel in Denver May 9-11. It is the joint, strictly scientific enterprise of the state medical associations of Colorado, Montana, New Mexico, Utah and Wyoming. The program, made up completely of speakers outside the Rocky Mountain region, includes the following:

John A. Anderson, San Francisco, Diagnosis and Treatment of Bulbar and Respiratory Poliomyelitis.
J. Vernon Luck, Los Angeles, Acute and Chronic Skeletal Infection Since the Antibiotics.
Martin T. Van Studdiford, New Orleans, Nummular-like Dermatoses and Sensitizations.
Donald G. Johnson, New York, Obstetric Hemorrhage.
Frank P. Foster, Boston, Simple Classification and Management of Functional Menstrual Disorders.
George M. Curtis, Columbus, Ohio, Current Management of Thyroid Disease.
Louis A. Buie, Rochester, Minn., Proctology from the Standpoint of the General Practitioner, the Internist and the Surgeon.

Full color television of medical and surgical clinics originating in Denver General Hospital will be shown at the hotel through the cooperation of Smith, Kline and French Laboratories of Philadelphia. The banquet and dance will be held Thursday evening at the Shirley-Savoy Hotel. Scientific and technical exhibits will be on display. The registration fee is $10.

FOREIGN

Bilharziasis Survey of the Middle East.—For the first time, bilharziasis-infected areas have been found in different parts of Saudi Arabia by Dr. M. Abdel Azim Bey, director of the rural hygiene department of the Egyptian Ministry of Public Health. The results of Dr. Abdel Azims's investigations will be communicated to the governments concerned by the WHO Eastern Mediterranean Regional Office in Alexandria, together with recommendations for the control of the debilitating disease which seriously diminishes the productivity of farm labor and peasants.

French Gastroenterology Meetings.—The French National Society of Gastroenterologists will meet June 16-17 in the auditorium of the Faculty of Medicine of Paris. Subjects under discussion will be Esophagitis and Esophageal Dyskinesias and Duodenitis and Dyskinesias of Duodenum. The university courses in Digestive Pathology will be given by the Faculty of Medicine of Paris and the society at the university and its hospital June 1-July 10. Courses will be under the direction of Professor Etienne Chabrol. They will consist of a series of lectures and practical demonstrations: Liver and Pancreas, June 1 to June 14; Esophagus, Stomach and Duodenum, June 15 to June 26, and Intestine, Rectum, Anus, June 27 to July 10. The registration fee is 3,000 French francs per section, 9,000 francs for all courses; the interns of the hospitals in university towns will benefit by a reduced fee. For information concerning either meeting address Dr. Francois Moutier, 78 rue de Monceau, Paris 3e.

Health Demonstration Project in El Salvador.—The government of El Salvador has signed an agreement to establish the first demonstration area in the Americas under the United Nations technical assistance program. The World Health Organization will furnish technical personnel, equipment and supplies, and training fellowships. WHO's contribution for the first year will be about $150,000. El Salvador, through its Ministry of Public Health and Assistance, will contribute about $200,000 the first year in health personnel, buildings and supplies. The government has already trained some 25 new specialists to work in the health project.

The district chosen for the demonstration is just north of the city of San Salvador, has a population of 100,000, is a rural area typical of many regions in Latin America, has important health problems and a qualified health leadership. The town of Quezaltepequen, of 16,000 population, to be used as headquarters for the demonstration area, has contributed the land on which construction of buildings will start immediately. Eleven other towns in the area are contributing facilities for clinics. Several have offered to contribute funds for sanitation facilities such as water and sewage systems. This aid is in addition to the government's contribution. Activities will include work in the field of environmental sanitation; maternal and child health; nutrition; control of malaria, tuberculosis, venereal diseases and other communicable diseases; dental hygiene; laboratory services; health education; general medical care, and public health training. The government has already selected another area, a coastal region along the Pacific, for the gradual extension of similar activities to be carried out through the government's own resources. The government of El Salvador was assisted in developing the health demonstration project by Dr. Milton I. Roemer, assistant professor of public health at Yale University, New Haven, Conn. Dr. Roemer, whose services were loaned to WHO by the university, has just completed a comprehensive 10 week survey of the republic's needs, together with a plan of operations.

DEATHS IN OTHER COUNTRIES

Dr. Frederick W. Routley, associated with the Canadian Red Cross Society since 1921 and its director from 1938 to 1948, died February 12 in Toronto, aged 70.——**Sir Leonard G. Parsons,** Birmingham, England, dean of the faculty of medicine of the University of Birmingham and professor emeritus of pediatrics and child health, died at his home in December.——**Wilhelm Schuffner** died recently at the age of 83. During his early years of medical practice in Sumatra, Dr. Schuffner made the discovery (1899) of the Schuffner's dots in Plasmodium vivax. In later years he was in charge of preventive medicine in the Netherlands Indies and then professor of tropical medicine at the Institut Colonial Royal d'Amsterdam, of which he was medical director from 1924 to 1937.

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MEETINGS

AMERICAN MEDICAL ASSOCIATION, Atlantic City, June 11 to 15. Dr. George F. Lull, 535 N. Dearborn St., Chicago 10, Secretary.

AERO MEDICAL ASSOCIATION, Denver, Colo., May 14-16. Dr. Thomas H. Sutherland, 214 S. State St., Marion, Ohio, Secretary.

ALASKA TERRITORIAL MEDICAL ASSOCIATION, Ketchikan, May 31-June 2. Dr. William P. Blanton, Box 2569, Juneau, Secretary.

AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS, Skytop Lodge, Skytop, Pa., May 16-18. Dr. Norris J. Heckel, 122 S. Michigan Ave., Chicago 3, Secretary.

AMERICAN ASSOCIATION ON MENTAL DEFICIENCY, Hotel New Yorker, New York, May 21-26. Dr. Neil A. Dayton, P. O. Box 96, Willimantic, Conn., Secretary.

AMERICAN BRONCHO-ESOPHAGOLOGICAL ASSOCIATION, Hotel Claridge, Atlantic City, May 7-8. Dr. Edwin N. Broyles, 1100 N. Charles St., Baltimore 1, Secretary.

AMERICAN COLLEGE OF CHEST PHYSICIANS, Atlantic City, June 7-10. Mr. Murray Kornfeld, 500 N. Dearborn St., Chicago 10, Executive Secretary.

AMERICAN COLLEGE OF RADIOLOGY, Atlantic City, June 10. Mr. W. C. Stronach, 20 N. Wacker Drive, Chicago 6, Executive Secretary.

AMERICAN DERMATOLOGICAL ASSOCIATION, The Homestead, Hot Springs, Va., May 23-26. Dr. Louis A. Brunsting, 102 Second Ave., S. W., Rochester, Minn., Secretary.

AMERICAN DIABETES ASSOCIATION, Chalfonte-Haddon Hall, Atlantic City, June 9-10. Dr. John A. Reed, 11 W. 42d St., New York 18, Secretary.

AMERICAN ELECTROENCEPHALOGRAPHIC SOCIETY, Hotel Claridge, Atlantic City, June 16-17. Dr. John A. Abbott, Massachusetts General Hospital, Boston 14, Secretary.

AMERICAN GASTRO-ENTEROLOGICAL ASSOCIATION, Atlantic City, June 8-9. Dr. Dwight L. Wilbur, 655 Sutter St., San Francisco 2, Secretary.

AMERICAN GERIATRICS SOCIETY, Hotel Brighton, Atlantic City, June 7-9. Dr. Malford W. Thewlis, 25 Mechanic St., Wakefield, R. I., Secretary.

AMERICAN GOITER ASSOCIATION, Deshler-Wallick Hotel, Columbus, Ohio, May 24-26. Dr. George C. Shivers, 100 E. St. Vrain St., Colorado Springs, Colo., Secretary.

AMERICAN GYNECOLOGICAL SOCIETY, Waldorf-Astoria Hotel, New York, May 7-9. Dr. Norman F. Miller, 1313 E. Ann St., Ann Arbor, Mich., Secretary.

AMERICAN LARYNGOLOGICAL ASSOCIATION, Hotel Claridge, Atlantic City, May 9-10. Dr. Louis H. Clerf, 1530 Locust St., Philadelphia 2, Secretary.

AMERICAN LARYNGOLOGICAL, RHINOLOGICAL AND OTOLOGICAL SOCIETY, Hotel Claridge, Atlantic City, May 6-8. Dr. C. Stewart Nash, 277 Alexander St., Rochester 7, N. Y., Secretary.

AMERICAN NEUROLOGICAL ASSOCIATION, Atlantic City, June 18-20. Dr. H. Houston Merritt, 710 W. 168th St., New York 32, Secretary.

AMERICAN OPHTHALMOLOGICAL SOCIETY, The Greenbrier, White Sulphur Springs, W. Va., June 7-9. Dr. Maynard C. Wheeler, 30 W. 59th St., New York 19, Secretary.

AMERICAN ORTHOPEDIC ASSOCIATION, The Greenbrier, White Sulphur Springs, W. Va., June 20-23. Dr. C. Leslie Mitchell, Henry Ford Hospital, Detroit 2, Secretary.

AMERICAN OTOLOGICAL SOCIETY, Hotel Claridge, Atlantic City, May 11-12. Dr. John Lindsay, 950 E. 59th St., Chicago 37, Secretary.

AMERICAN PEDIATRIC SOCIETY, Atlantic City, May 2-5. Dr. Henry G. Poncher, 1819 W. Polk St., Chicago 12, Secretary.

AMERICAN PHYSIOLOGICAL SOCIETY, Cleveland, April 30-May 4. Dr. R. W. Gerard, Dept. of Physiology, University of Chicago, Chicago, Secretary.

AMERICAN PROCTOLOGIC SOCIETY, Atlantic City, June 7-10. Dr. W. Wendell Green, 1838 Parkwood Ave., Toledo 2, Ohio, Secretary.

AMERICAN PSYCHIATRIC ASSOCIATION, Cincinnati, May 7-11. Dr. R. Finley Gayle Jr., 501 E. Franklin St., Richmond 19, Va., Secretary.

AMERICAN PSYCHOANALYTIC ASSOCIATION, Netherland Plaza Hotel, Cincinnati, Ohio, May 4-6. Dr. LeRoy M. A. Maeder, 1910 Rittenhouse Square, Philadelphia 3, Secretary.

AMERICAN RADIUM SOCIETY, Atlantic City, June 6-9. Dr. John Wirth, U. S. Marine Hospital, Baltimore, Secretary.

AMERICAN RHEUMATISM ASSOCIATION, Hotel Dennis, Atlantic City, June 8-9. Dr. Charles Ragan, 620 W. 168th St., New York 32, Secretary.

AMERICAN SOCIETY FOR CLINICAL INVESTIGATION, Steel Pier, Atlantic City, April 30. Dr. Paul B. Beeson, Grady Hospital, Atlanta 3, Ga., Secretary.

AMERICAN SOCIETY FOR EXPERIMENTAL PATHOLOGY, Cleveland, April 30-May 4. Dr. Sidney C. Madden, Brookhaven National Laboratory, Upton, L. I., New York. Secretary.

AMERICAN SOCIETY FOR PHARMACOLOGY AND EXPERIMENTAL THERAPEUTICS, Cleveland, April 28-May 4. Dr. Harvey B. Haag, Medical College of Virginia, Richmond 19, Va., Secretary.

AMERICAN SOCIETY FOR THE STUDY OF STERILITY, Ritz-Carlton Hotel, Atlantic City, June 9-10. Dr. John O. Haman, 490 Post St., San Francisco 2, Secretary.

AMERICAN SOCIETY OF BIOLOGICAL CHEMISTS, Cleveland, April 28-May 4. Dr. Elmer H. Stotz, University of Rochester School of Medicine, Rochester 7, N. Y., Secretary.

AMERICAN THERAPEUTIC SOCIETY, Atlantic City, June 8-10. Dr. Oscar B. Hunter, 915 Nineteenth St. N.W., Washington 6, D. C., Secretary.

AMERICAN UROLOGICAL ASSOCIATION, Palmer House, Chicago, May 21-24. Dr. Charles H. deT. Shivers, Boardwalk National Arcade Bldg., Atlantic City, N. J., Secretary.

ARIZONA MEDICAL ASSOCIATION, Tucson, April 29-May 2. Dr. Frank J. Milloy, 234 North Central Ave., Phoenix, Secretary.

ASSOCIATION FOR THE STUDY OF INTERNAL SECRETIONS, Chalfonte-Haddon Hall, Atlantic City, June 7-9. Dr. Henry H. Turner, 1200 N. Walker St., Oklahoma City 3, Secretary.

ASSOCIATION OF AMERICAN PHYSICIANS, Chalfonte-Haddon Hall, Atlantic City, May 1-2. Dr. Henry M. Thomas Jr., 1201 N. Calvert St., Baltimore 2, Secretary.

CALIFORNIA MEDICAL ASSOCIATION, Hotel Biltmore, Los Angeles, May 13-16. Dr. Albert C. Daniels, 450 Sutter St., San Francisco 8, Secretary.

CATHOLIC HOSPITAL ASSOCIATION OF THE UNITED STATES AND CANADA, Convention Hall, Philadelphia, June 2-5. Mr. M. R. Kneifl, 1402 S. Grand Blvd., St. Louis 4, Executive Secretary.

CONFERENCE OF PRESIDENTS AND OTHER OFFICERS OF STATE MEDICAL ASSOCIATIONS, Hotel Traymore, Atlantic City, June 10. Mr. John E. Farrel, 106 Francis St., Providence 3, R. I., Secretary.

CONNECTICUT STATE MEDICAL SOCIETY, Stratford, May 1-3. Dr. Creighton Barker, 160 St. Ronan St., New Haven, Secretary.

FEDERATION OF AMERICAN SOCIETIES FOR EXPERIMENTAL BIOLOGY, Cleveland, April 28-May 4. Dr. Milton O. Lee, 2101 Constitution Ave., Washington 25, D. C., Secretary.

HAWAII TERRITORIAL MEDICAL ASSOCIATION, Honolulu, May 3-6. Dr. I. L. Tilden, 510 S. Beretania St., Honolulu 13, Secretary.

IDAHO STATE MEDICAL ASSOCIATION, Sun Valley, June 17-20. Dr. Robert S. McKean, 305 Sun Building, Boise, Secretary.

ILLINOIS STATE MEDICAL SOCIETY, Hotel Sherman, Chicago, May 22-24. Dr. Harold M. Camp, 224 S. Main St., Monmouth, Secretary.

KANSAS MEDICAL SOCIETY, Topeka, May 14-17. Dr. D. D. Vermillion, 512 New England Bldg., Topeka, Secretary.

LOUISIANA STATE MEDICAL SOCIETY, New Orleans, May 7-9. Dr. C. Grenes Cole, 1430 Tulane Ave., New Orleans 12, Secretary.

MAINE MEDICAL ASSOCIATION, Poland Spring House, Poland Spring, June 17-19. Dr. Frederick R. Carter, 142 High St., Portland 3, Secretary.

MASSACHUSETTS MEDICAL SOCIETY, Hotel Statler, Boston, May 22-24. Dr. H. Quimby Gallupe, 8 Fenway, Boston 15. Secretary.

MINNESOTA STATE MEDICAL ASSOCIATION, Municipal Auditorium, Rochester, April 30-May 2. Dr. B. B. Souster, 496 Lowry Medical Arts Bldg., St. Paul 2, Secretary.

MISSISSIPPI STATE MEDICAL ASSOCIATION, Biloxi, May 15-17. Dr. T. M. Dye, Box 295, Clarksdale, Secretary.

NATIONAL TUBERCULOSIS ASSOCIATION, Cincinnati, Ohio, May 14-18. Dr. James E. Perkins, 1790 Broadway, New York 19, Managing Director.

NEBRASKA STATE MEDICAL ASSOCIATION, Paxton Hotel, Omaha, April 30-May 3. Dr. R. B. Adams, 1315 Sharp Bldg., Lincoln 8, Secretary.

NEW JERSEY, MEDICAL SOCIETY OF, Haddon Hall, Atlantic City, May 14-17. Dr. Marcus H. Greifinger, 315 W. State St., Trenton 8, Secretary.

NEW MEXICO MEDICAL SOCIETY, Santa Fe, May 3-5. Dr. L. G. Rice Jr., 221 West Central Ave., Albuquerque, Secretary.

NEW YORK, MEDICAL SOCIETY OF THE STATE OF, Hotel Statler, Buffalo, April 30-May 4. Dr. Walter P. Anderton, 292 Madison Ave., New York 17, Secretary.

NORTH CAROLINA, MEDICAL SOCIETY OF THE STATE OF, The Carolina, Pinehurst, May 7-9. Dr. Millard D. Hill, 203 Capitol Club Bldg., Raleigh, Secretary.

NORTH DAKOTA STATE MEDICAL ASSOCIATION, Bismarck, May 19-22. Dr. O. A. Sedlak, 702 First Ave. S., Fargo, Secretary.

OKLAHOMA STATE MEDICAL ASSOCIATION, Mayo Hotel, Tulsa, May 21-23. Mr. R. H. Graham, 1227 Classen St., Oklahoma City, Executive Secretary.

RHODE ISLAND MEDICAL SOCIETY, Providence, May 9-10. Dr. Morgan Cutts, 106 Francis St., Providence 3, Secretary.

SECTIONAL MEETING, AMERICAN COLLEGE OF SURGEONS:
Detroit, Mich., Book-Cadillac Hotel, May 9-11. Dr. Eugene A. Osius, 1553 Woodward Ave., Detroit 26, Chairman.

SOCIETY FOR INVESTIGATIVE DERMATOLOGY, Ritz-Carlton Hotel, Atlantic City, June 7-8. Dr. Herman Beerman, 255 S. 17th St., Philadelphia, Secretary

SOCIETY FOR PEDIATRIC RESEARCH, Hotel Traymore, Atlantic City, May 2-3. Dr. Robert Ward, Bellevue Medical Center, New York 16, Secretary.

SOCIETY OF AMERICAN BACTERIOLOGISTS, Chicago, May 28-June 1. Dr. John E. Blair, 1919 Madison Ave., New York 35, Secretary.

SOUTH CAROLINA MEDICAL ASSOCIATION, Ocean Forest Hotel, Myrtle Beach, May 15-17. Dr. N. B. Heyward, 105 W. Cheves St., Florence, Secretary.

SOUTH DAKOTA STATE MEDICAL ASSOCIATION, Aberdeen, June 2-6. Dr. Roland G. Mayer, 22½ S. Main St., Aberdeen, Secretary.

TEXAS, STATE MEDICAL ASSOCIATION OF, Galveston, April 28-May 2. Mr. Tod Bates, 700 Guadalupe St., Austin, Executive Secretary.

INTERNATIONAL

EUROPEAN CONGRESS ON RHEUMATISM, Barcelona, Spain, Sept. 24-27. Dr. Gunnar Edström, Lund, Sweden, Secretary.

INTERNATIONAL ACADEMY OF PROCTOLOGY, Atlantic City, N. J., U. S. A., June 14-15. Dr. Alfred J. Cantor, 43-45 Kissena Blvd., Flushing, New York, Secretary.

INTERNATIONAL ANESTHESIA RESEARCH SOCIETY, London, England, Sept. 3-7. Mr. R. W. Cope, University College Hospital, London W.C.1, England.

INTERNATIONAL ASSOCIATION OF ALLERGISTS, Zurich, Switzerland, Sept. 23-29. Prof. A. S. Grumbach, Hygiene Institut der Universitaet Zurich, Gloriastr. 32, Zurich, Switzerland.

INTERNATIONAL CONGRESS OF ANESTHESIOLOGY, Nursing School of the Salpiettre, 47 Boul de l'Hospital, Paris, France, Sept 20-22. 12 rue de Seine, Paris 6e, France, Secretariat.

INTERNATIONAL CONGRESS OF CLINICAL PATHOLOGY, London, England, July 16-20. Dr. W. H. McMenemey, Maida Vale Hospital for Nervous Diseases, London W.9, England, Secretary.

INTERNATIONAL CONGRESS OF GYNECOLOGY, Maison de la Chimie, Centre Marcellin, Paris, France, June 23-29. Dr. Maurice Fabre, 1, rue Jules-Lefebvre, Paris IX, General Secretary.

INTERNATIONAL CONGRESS ON MENTAL HEALTH, Mexico City, Mexico, Dec. 11-19.

INTERNATIONAL CONGRESS OF MILITARY MEDICINE AND PHARMACY, Paris, France, June 17-23. Physician General Dutrey, 8, bis, rue de Recollets, Paris X, Secretary General.

INTERNATIONAL CONGRESS OF ORTHOPEDIC SURGERY AND TRAUMATOLOGY, Stockholm, Sweden, May 21-25. Dr. Anders Karlen, Karolinska Instituts Ortopediska Klinik, Stockholm, Secretary.

INTERNATIONAL EXHIBITION OF MEDICAL ARTS, Turin, Italy, May 30-June 12. Prof. S. Teneff, Palazzo della Exposizioni al Valentino, Turino, Italy.

INTERNATIONAL GERONTOLOGICAL CONGRESS, Hotel Jefferson, St. Louis, Mo., U. S. A., Sept. 9-14. Dr. John E. Kirk, 5600 Arsenal Street, St. Louis 9, Mo., Chairman, Program Committee.

INTERNATIONAL HOSPITAL CONGRESS, Brussels, Belgium, July 15-21. Capt. J. E. Stone, 10 Old Jewry, London E.C., England, Secretary.

INTERNATIONAL POLIOMYELITIS CONGRESS, Copenhagen, Denmark, Sept. 3-7. Prof. Dr. Niels Bohr, Statens Seruminstitut, 80 Amager Blvd., Copenhagen S., Denmark, President.

INTERNATIONAL SOCIETY OF ANGIOLOGY, Claridge Hotel, Atlantic City, N. J., U. S. A., June 9. Dr. Henry Haimovici, 105 E. 90th St., New York 28, Secretary.

INTERNATIONAL SOCIETY OF SURGERY, Paris, France, Sept. 24-29. Dr. L. Dejardin, 141, rue Belliard, Brussels, Belgium, Secretary General.

INTERNATIONAL SOCIETY FOR THE WELFARE OF CRIPPLES, Fifth World Congress, Stockholm, Sweden, Sept. 9-14. Mr. Donald V. Wilson, 54 E. 64th St., New York 21, N. Y., U. S. A., Executive Director.

PAN AMERICAN CONGRESS ON MEDICAL EDUCATION, Lima, Peru, May 14-18. Dr. Carlos F. Krumdieck, Washington 914, Lima, Secretary General.

PAN PACIFIC SURGICAL ASSOCIATION CONGRESS, Honolulu, Hawaii, Nov. 10-21. Dr. Forrest J. Pinkerton, Suite 7, Young Bldg., Honolulu, Hawaii, President.

WORLD CONFEDERATION FOR PHYSICIAL THERAPY, Copenhagen, Denmark, Sept. 7-8.

WORLD MEDICAL ASSOCIATION, Stockholm, Sweden, Sept. 15-21. Dr. Louis H. Bauer, 2 E. 103d St., New York 29, N. Y., U. S. A., Secretary-General.

EXAMINATIONS AND LICENSURE

NATIONAL BOARD OF MEDICAL EXAMINERS

NATIONAL BOARD OF MEDICAL EXAMINERS: *Parts I and II.* Various Centers. April 16-17 (Part II only), June 18-20, Sept. 5-7 (Part I only). Applications must be filed at least thirty days prior to an examination. Ex. Sec., Mr. E. S. Elwood, 225 S. 15th Street, Philadelphia.

EXAMINING BOARDS IN SPECIALTIES

AMERICAN BOARD OF ANESTHESIOLOGY: *Written.* July 20. Given simultaneously in several cities in the United States. Final date for filing application was Jan. 20. *Oral.* Memphis, Oct. 14-17. Sec., Dr. Curtiss B. Hickcox, 80 Seymour St., Hartford 15, Conn.

AMERICAN BOARD OF DERMATOLOGY AND SYPHILOLOGY: *Oral.* New York, June 8-10. Sec., Dr. George M. Lewis, 66 East 66th St., New York 21, N. Y.

AMERICAN BOARD OF INTERNAL MEDICINE: *Written.* Various centers, Oct. 15. Final date for filing applications is May 1. *Oral.* The schedule of oral examinations for 1951 has been arranged on a regional basis as follows: June, includes candidates from Beirut, Canada, Canal Zone, Connecticut, Delaware, District of Columbia, Maryland, New Jersey, Ohio, Pennsylvania, Puerto Rico, Rhode Island, Virginia and West Virginia. New York, date to be announced, covering Maine, Massachusetts, New Hampshire, New York and Vermont. San Francisco, date to be announced, Arizona, California, Colorado, Idaho, Montana, New Mexico, Oregon, Utah and Washington.

Only candidates who have not taken an oral examination can be admitted under the schedule arranged thus far.

Dates of closing dates for the filing of applications for examinations in New York and San Francisco to be announced.

Oral examinations in the subspecialties will be held at the same time and place and on the same distribution.
Exec. Sec., Dr. William A. Werrell, 1 West Main Street, Madison 3.

AMERICAN BOARD OF NEUROLOGICAL SURGERY: *Oral.* Chicago, May 1951. Sec., Dr. W. J. German, 789 Howard Ave., New Haven 4, Conn.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY: *Oral.* New York City, May 10-16. Final date for filing application was Feb. 2. Sec., Dr. Paul Titus, 1015 Highland Building, Pittsburgh 6, Pa.

AMERICAN BOARD OF OPHTHALMOLOGY: *Oral.* New York, May 31-June 5; Chicago, October 8-13. Sec., Dr. Edwin B. Dunphy, 56 Ivie Road, Cape Cottage, Maine.

AMERICAN BOARD OF ORTHOPAEDIC SURGERY: *Part I.* San Francisco, May 11-12. Final date for filing applications for the 1952 Part II examinations is Aug. 15, 1951. Sec., Dr. Harry A. Sofield, 122 S. Michigan Ave., Chicago 3.

AMERICAN BOARD OF OTOLARYNGOLOGY: *Oral.* Richmond, Va., May 1-4, Chicago, Oct. 9-12. Sec., Dr. Dean M. Lierle, University Hospital, Iowa City.

AMERICAN BOARD OF PEDIATRICS: *Oral.* Atlantic City, May 5-7. Detroit, June 8-10. This examination replaces the one originally scheduled for Cleveland in June. Ex. Sec., Dr. John McK. Mitchell, 6 Cushman Road, Rosemont, Pa.

AMERICAN BOARD OF PHYSICAL MEDICINE AND REHABILITATION: *Parts I and II.* Philadelphia, June 16-17. Final date for filing application is April 1. Sec., Dr. Robert L. Bennett, 30 N. Michigan Ave., Chicago.

AMERICAN BOARD OF PLASTIC SURGERY: *Oral and Written.* Chicago, June 4-6. Final date for filing application is March 15. Sec., Dr. Bradford Cannon, 330 Dartmouth St., Boston.

AMERICAN BOARD OF PROCTOLOGY: *Part I in Anorectal Surgery and Proctology.* Kansas City, Minneapolis, Philadelphia and San Francisco, May 12. Sec.-Gen., Dr. Louis A. Buie, 102-110 Second Ave., S.W., Rochester, Minn.

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY: Philadelphia, June 11-12. Final date for filing application was March 1. Sec., Dr. Francis J. Braceland, 102-110 Second Ave., S.W., Rochester, Minn.

AMERICAN BOARD OF RADIOLOGY: *Oral.* Atlantic City, June 5-9. Sec., Dr. B. R. Kirklin, 102-110 Second Ave., S.W., Rochester, Minn.

AMERICAN BOARD OF SURGERY: *Written.* Various centers, Oct. 1951. Final date for filing applications is July 1. Sec., Dr. J. Stewart Rodman, 225 South 15th Street, Philadelphia.

AMERICAN BOARD OF UROLOGY: Chicago, Feb. 9-13, 1952. Final date for filing applications is Sept. 1. Sec., Dr. Harry Culver, 314 Corn Exchange Bldg., Minneapolis 15.

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DEATHS

Meyer, Theodore Roosevelt ⊕ Sag Harbor, N. Y.; born in Sag Harbor March 28, 1897; Medical College of the State of South Carolina, Charleston, 1924; served with the American Expeditionary Forces in France in World War I; a lieutenant commander, commander and captain in the U. S. Naval Reserve during World War II; chief of the medical research and training section, Office of Military Government for Germany, where he acted as consultant on medical research projects undertaken by German personnel; in 1946 received the Cross of the Order of Taxiarchis from King George II of Greece for services rendered to that country as officer in charge of a Navy epidemiologic unit; past president of the Missouri Public Health Association; fellow of the American Public Health Association; at various times served as county and city commissioner in South Carolina, West Virginia, Ohio, Michigan and Missouri; in 1949 assumed the directorship of the Tri-County Health District in Denver, where he served as commissioner of health for Adams, Arapahoe and Jefferson counties; received the doctor of public health degree from Yale University in New Haven, Conn., in 1933; died in Southampton (N. Y.) Hospital February 12, aged 53, of arteriosclerotic heart disease.

Collinson, John, Elkton, Md.; born in South River, Md., Dec. 31, 1886; Johns Hopkins University School of Medicine, Baltimore, 1911; received the doctor of public health degree from Johns Hopkins School of Hygiene and Public Health in 1923; associated with the International Health Board from 1913 to 1916; a deputy state health officer from 1916 to 1918 and appointed again in 1942; served during World War I; assistant chief of the Bureau of Communicable Diseases from 1919 to 1928 and chief of the Bureau of Vital Statistics of the State Department of Health from 1928 to 1935, when he became assistant chief statistician for the division of vital statistics of the Bureau of Census in Washington, D. C.; served as health officer of Cecil County; member of the American Medical Association, American Association of State Registration Executives and the American Academy of Political and Social Science; fellow of the American Public Health Association and served as secretary of its section on vital statistics; killed December 14, aged 63, in an automobile accident.

Rickard, Elsmere Rife, Tampa, Fla.; born in Weeping Water, Neb., Feb. 1, 1900; Northwestern University Medical School, Chicago, 1924; specialist certified by the American Board of Public Health; for many years associated with the International Health Division of the Rockefeller Foundation; during his early service with the foundation carried on tropical disease research in South America; a member of the commission on influenza of the board for the investigation and control of influenza and other epidemic diseases in the Army during World War II; made several surveys of typhus in the South and in 1946 was assigned to the Florida State Board of Health for typhus research; recently named director of the new health unit of Lee County; died in Fort Myers, Fla., January 16, aged 50, of coronary thrombosis and hypertensive heart disease.

Swinney, Robert Harold ⊕ Portland, Ore.; born in Cement, Okla., Sept. 22, 1905; Washington University School of Medicine, St. Louis, 1935; clinical associate in surgery at the University of Oregon Medical School; a member of the board of directors and trustee of the Oregon Physicians' Service for Multnomah County and for many years chairman of the advisory committee; specialist certified by the American Board of Surgery; certified by the National Board of Medical Examiners; one of the founders and past president of the Portland Surgical Society; a member of the Portland Academy of Medicine; on the staffs of St. Vincent's and Good Samaritan hospitals; drowned February 8, aged 45, when his boat in which he was fishing capsized in the Lewis River 17 miles north of Vancouver, Wash.

⊕ Indicates Fellow of the American Medical Association.

Baker, Archibald E. ⊕ Charleston, S. C.; born in Charleston, April 16, 1895; Medical College of the State of South Carolina, Charleston, 1921; formerly professor of gynecology and abdominal surgery and lecturer in surgery at his alma mater; past president, vice president and councilor of the Tri-State Medical Association of Virginia and the Carolinas; for many years member of the board of directors of the South Carolina Hospital Association; member of the Southeastern Surgical Congress; fellow of the American College of Surgeons; served on the Mexican border in 1916 and later served during World War I; formerly on the staff of Roper Hospital; president and at one time medical director of Baker Memorial Sanatorium, where he died January 25, aged 55, of cerebral hemorrhage and hypertension.

Davis, Henry Blaine ⊕ Lancaster, Pa.; born in Philadelphia in 1884; University of Pennsylvania School of Medicine, Philadelphia, 1910; specialist certified by the American Board of Radiology; member of the American College of Radiology; past president of the Pennsylvania Radiological Society; served during World War I; an officer of the Pennsylvania National Guard and from 1928 to 1942 held the rank of major in the medical reserve corps of the U. S. Army; formerly deputy coroner of Manheim Township; affiliated with Lancaster General and St. Joseph's hospitals and Rossmere Sanatorium; at one time physician to the Lancaster County Prison; died in Brunswick, Ga., December 20, aged 66, of arteriosclerosis and cerebral hemorrhage.

Manion, James Lorne ⊕ Commander, U. S. Navy, retired, Coronado, Calif.; born in Portland, Ore., Nov. 6, 1885; Jefferson Medical College of Philadelphia, 1910; served as deputy health officer of Portland, Ore.; entered the medical corps of the U. S. Navy in 1913; during World War II served at the Naval Hospital, Norfolk, and later at Base Hospital no. 5 in France; served several years with the U. S. Marines in China; his last active duty station was the Naval Amphibious Training Base in Coronado; on June 30, 1940, was placed on the retired list but remained on active duty until May 8, 1946; died in the U. S. Naval Hospital, San Diego, January 22, aged 65, of aortic stenosis.

Davis, David ⊕ Washington, D. C.; Johns Hopkins University School of Medicine, Baltimore, 1922; member of the American Academy of Ophthalmology and Otolaryngology; specialist certified by the American Board of Otolaryngology; associate in otorhinolaryngology at George Washington University School of Medicine and University Hospital; on the staffs of Gallinger Municipal, Episcopal, Eye, Ear and Throat and Saint Elizabeth's hospitals and the Tuberculosis Sanatorium in Glen Dale, Md.; served during World War I; died in George Washington University Hospital January 18, aged 55.

Beatty, James David ⊕ Pacific Palisades, Calif.; born in Sigourney, Iowa, in 1879; Washington University School of Medicine, St. Louis, 1901; specialist certified by the American Board of Otolaryngology; member of the Pacific Coast Oto-Ophthalmological Society; fellow of the American College of Surgeons; an Associate Fellow of the American Medical Association; honorary member of the staff of Methodist Hospital of Southern California, Cedars of Lebanon Hospital and Presbyterian Hospital-Olmsted Memorial, all in Los Angeles; died in Los Angeles January 3, aged 71, of coronary thrombosis.

Lewis, Jacques Melvin ⊕ New York; born in New York Dec. 13, 1900; University and Bellevue Hospital Medical College, New York, 1923; professor of pediatrics at his alma mater, now known as the New York University College of Medicine; specialist certified by the American Board of Pediatrics; fellow of the American Pediatric Society and the American Academy of Pediatrics; president of the medical board and on the staff of Beth Israel Hospital; on the staff of Bellevue Hospital; died in Miami Beach, Fla., January 29, aged 50, of cerebral embolism and hypertensive heart disease.

Clark, Dwight Freeman ✠ Evanston, Ill.; Rush Medical College, Chicago, 1903; fellow of the American College of Surgeons; member of the founders group of the American Board of Surgery; member and past president of the Illinois State Historical Society; president of the Evanston Historical Society; member of the American Association of Railway Surgeons; served as associate in surgery at Northwestern University Medical School in Chicago; affiliated with Evanston Hospital, where he died January 4, aged 72, of adenocarcinoma of the colon.

Arent, Asaph, Humboldt, Iowa; State University of Iowa College of Medicine, Iowa City, 1898; member of the American Medical Association; for many years city physician and health officer; during World War I member of the county selective service board; affiliated with Lutheran and Mercy hospitals; died January 21, aged 73, of cerebral hemorrhage.

Burns, Arthur Silver, Leonia, N. J.; McGill University Faculty of Medicine, Montreal, Canada, 1903; died recently, aged 71.

Caine, Vaughn Holmes, Orrville, Ala.; Medical College of Alabama, Mobile, 1892; member of the American Medical Association; died in Baptist Hospital, Selma, January 28, aged 82, of cerebral hemorrhage.

Cleaves, Ezra Eames, Rockport, Mass.; Harvard Medical School, Boston, 1900; past president of the Essex South District Medical Society; member of the American Medical Association; served as chairman of the board of health of Rockport, member of the public health committee and as school physician; for many years secretary of the medical staff of the Addison Gilbert Hospital in Gloucester, where he died January 9, aged 76, of coronary thrombosis.

Coerper, E. E., Fredonia, Wis.; Milwaukee Medical College, 1897; died in St. Joseph Hospital, West Bend, January 15, aged 78, of arteriosclerosis.

Coffman, Joseph S. ✠ Lavaca, Ark.; College of Physicians and Surgeons, Little Rock, 1907; formerly member of the school board; director of the Bank of Lavaca; died in Sparks' Memorial Hospital in Fort Smith December 30, aged 71, of coronary thrombosis.

Connelly, John Julian ✠ Terre Haute, Ind.; University of Louisville (Ky.) Medical Department, 1913; served during World War I; on the staff of Union Hospital; died January 12, aged 59, of coronary occlusion.

Cook, Clarence Percy, Des Moines, Iowa; College of Physicians and Surgeons, Keokuk, 1899; University of Colorado School of Medicine, Denver, 1911; also a graduate in pharmacy; member of the American Medical Association; on the staffs of the Iowa Methodist, Iowa Lutheran and Broadlawns hospitals; died recently, aged 79, of coronary occlusion.

Cooley, Mahlon Cecil, Los Angeles; Meharry Medical College, Nashville, Tenn., 1916; member of the American Medical Association; died January 27, aged 61.

Corbin, George Clarence, Boston; Howard University College of Medicine, Washington, D. C., 1942; member of the American Medical Association; served during World War II; affiliated with Beth Israel Hospital, where he died recently, aged 34, of leukemia.

Daly, Thomas Jefferson, Fort Worth, Texas; Beaumont Hospital Medical College, St. Louis, 1891; died January 23, aged 84, of a fractured hip and cerebral hemorrhage.

Davis, Amos M., Ashland, Ky.; University of Louisville Medical Department, 1911; member of the American Medical Association; died in Sebastian, Fla., recently, aged 67, of coronary thrombosis.

Delehanty, Nicholas James, Rutland, Vt.; Albany (N. Y.) Medical College, 1899; served during World War I; died in the Veterans Administration Hospital in White River Junction January 17, aged 77.

Dexter, Henry Leon, Bayonne, N. J.; Jefferson Medical College of Philadelphia, 1895; formerly a lawyer; died January 19, aged 85, of heart disease.

Emery, William Gordon, Barnard, Kan.; New York Homeopathic Medical College and Hospital, New York, 1899; member of the American Medical Association; county health officer; served on the staffs of Asbury and St. John's hospitals in Salina; died January 25, aged 77, of arteriosclerosis.

Enderlin, Albert Joseph, Columbus, Ohio; University of Pittsburgh School of Medicine, 1911; member of the American Medical Association and the American Association of Industrial Physicians and Surgeons; served as president of the city board of health; affiliated with St. Anthony's Hospital, Grant Hospital and Mount Carmel Hospital, where he died January 31, aged 63.

Fairhall, Leo Victor, Danville, Ill.; College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, 1906; member of the American Medical Association; died January 22, aged 70, of cirrhosis of the liver.

Findley, William John, Storm Lake, Iowa; Northwestern University Medical School, Chicago, 1894; member of the American Medical Association; died in Sioux City recently, aged 91, as the result of a fractured hip.

Fisher, Ward Lyford ✠ Pomona, Calif.; College of Physicians and Surgeons, Los Angeles, 1914; fellow of the American College of Surgeons; on the staff of the Pomona Valley Community Hospital; died January 29, aged 63, of coronary thrombosis.

Gallaher, Joseph Alonzo, Lawrenceburg, Tenn.; University of Tennessee Medical Department, Nashville, 1900; died December 8, aged 71, of coronary thrombosis.

Givens, James Martin ✠ Fort Worth, Texas; Fort Worth School of Medicine, Medical Department of Texas Christian University, 1906; on the staff of St. Joseph's Hospital; died January 10, aged 74.

Green, Thomas E., Chatsworth, Ga.; Georgia College of Eclectic Medicine and Surgery, Atlanta, 1900; died in the Murray County Memorial Hospital January 21, aged 71.

Grove, Emil Gustaf, Shelbyville, Ind.; Keokuk (Iowa) Medical College, 1896; died in the W. S. Major Hospital January 26, aged 78.

Guest, James C. A. ✠ Wichita Falls, Texas; Memphis (Tenn.) Medical College, 1903; past president and secretary of the Wichita County Medical Society; on the staff of the Wichita Falls Clinic-Hospital; died recently, aged 76, of cerebral thrombosis.

Gulyassy, Nicholas Stephen, Cleveland; Loyola University School of Medicine, Chicago, 1948; interned at St. Vincent Charity Hospital in Cleveland and served a residency at the Huron Road Hospital in East Cleveland; served as chief resident physician at Marymount Hospital in Garfield Heights, Ohio, where he died January 18, aged 28, of rheumatic heart disease.

Jaisohn, Philip ✠ Media, Pa.; Columbian University Medical Department, Washington, D. C., 1892; on the staff of the Chester (Pa.) Hospital; formerly adviser to the emperor and privy council of Korea; died in Montgomery Hospital, Norristown, January 5, aged 81.

Jeter, Drayton O., Alpine, Texas (licensed in Texas, by years of practice); member of the American Medical Association; died January 31, aged 71, of pulmonary fibrosis and cor pulmonale.

Jones, Robert Rivers Jr., Lawrenceville, Va.; Medical College of Virginia, Richmond, 1891; died in Brodnax January 25, aged 88, of carcinoma of stomach with metastases to liver.

Kafer, Oswald Ottmar, Edward, N. C.; University of Maryland School of Medicine, Baltimore, 1905; founder of Kafer Memorial Hospital in New Bern; died January 28, aged 70, of coronary thrombosis.

Kramer, Joseph G. ✠ Macomb, Ill.; Medico-Chirurgical College of Philadelphia, 1899; an Associate Fellow of the American Medical Association; one of the founders and for many years on the staff of the Good Samaritan Hospital; died in St. Francis Hospital January 16, aged 81, of acute coronary thrombosis.

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Kuder, William Solomon ✠ Oakland, Calif.; University of Pennsylvania Department of Medicine, Philadelphia, 1904; served during World War I; on the staff of the Peralta Hospital; died January 29, aged 68, of carcinoma of the lung.

LaMantia, Louis Napoleon, Buffalo; University of Buffalo School of Medicine, 1915; member of the American Medical Association; died recently, aged 62, of cerebral hemorrhage and hypertension.

Ledford, George, Altadena, Calif.; Beaumont Hospital Medical College, St. Louis, 1888; died recently, aged 80.

Lehman, Samuel John, Brainerd, Minn.; University of Minnesota Medical School, Minneapolis, 1944; member of the American Medical Association; died in St. Cloud January 10, aged 32.

Lehrbach, Lester Martin, Roseburg, Ore.; Northwestern University Medical School, Chicago, 1906; member of the American Medical Association; died January 27, aged 67, of carcinoma.

Light, Charles Harner ✠ Centre Hall, Pa.; University of Pennsylvania School of Medicine, Philadelphia, 1931; died in Geisinger Memorial Hospital in Danville January 26, aged 48.

Long, Joseph M., St. Louis; Missouri Medical College, St. Louis, 1880; died January 26, aged 95.

Loucks, Milo Marvin, Kelliher, Minn.; University of Minnesota Medical School, Minneapolis, 1930; died January 29, aged 48.

MacInnis, Donald Francis, Minneapolis; Marquette University School of Medicine, Milwaukee, 1936; member of the American College of Chest Physicians; died January 21, aged 42, of cor pulmonale and pulmonary fibrosis.

MacRae, Murdoch F. ✠ Milwaukee; Milwaukee Medical College, 1912; fellow of the American College of Surgeons; member, surgical staff, St. Joseph's Hospital; on the surgical consulting staff, Evangelical Deaconess Hospital; died in Wauwatosa, January 25, aged 72, of edema of lungs and carcinoma of the prostate.

Mason, James S. ✠ Urbana, Ill.; Northwestern University Medical School, Chicago, 1894; fellow of the American College of Surgeons; past president of the Champaign County Medical Society; on the emeritus staff of Burnham City Hospital in Champaign, where he died January 8, aged 82, of cerebral hemorrhage.

Maxwell, John Charles, Paw Paw, Mich.; University of Michigan Department of Medicine and Surgery, Ann Arbor, 1895; member of the American Medical Association; died in Lake View Community Hospital January 30, aged 84, of cerebral hemorrhage.

Minder, Delbert A., Columbus, Ohio; Ohio State University College of Medicine, Columbus, 1930; member of the American Medical Association; served during World War II; affiliated with Mercy Hospital; died January 30, aged 47, of heart failure.

Minner, Louis Augustus, Carbondale, Ill.; St. Louis College of Physicians and Surgeons, 1898; Jefferson Medical College of Philadelphia, 1900; served on the staff of St. Andrew's Hospital in Murphysboro; died January 18, aged 90, of intestinal obstruction.

Missildine, John Gurley ✠ Wichita, Kan.; University of Maryland School of Medicine, Baltimore, 1911; served overseas during World War I; affiliated with St. Francis Hospital and the Veterans Administration Hospital; died January 30, aged 66, of coronary thrombosis.

Moulton, Herbert ✠ Fort Smith, Ark.; Chicago Medical College, 1884; specialist certified by the American Board of Ophthalmology; fellow of the American Academy of Ophthalmology and Oto-Laryngology, International Congress of Ophthalmology and American College of Surgeons; member of the Southern Medical Association; past president of the Arkansas Medical Society; on the staffs of St. Edward's Mercy and Sparks' Memorial hospitals; died January 23, aged 90, of cerebral hemorrhage.

Murphy, Grover Eugene, Birmingham, Ala.; Birmingham Medical College, 1911; specialist certified by the American Board of Otolaryngology; served during World War II; member of the American Medical Association; died January 1, aged 64, probably of heart disease.

Neel, William Vickers, Henderson, Ky.; Southwestern Homeopathic Medical College and Hospital, Louisville, 1902; past president of the Henderson County Medical Society; for many years president of the city board of health; member of the American Medical Association; affiliated with Methodist Hospital, where he died January 30, aged 72, of carcinoma.

Newman, John Ross, Fort Scott, Kan.; Central Medical College of St. Joseph, Mo., 1905; member of the American Medical Association; died January 23, aged 69, of coronary thrombosis and chronic lymphatic leukemia.

Oldenbourg, Louise Augusta ✠ Berkeley, Calif.; University of California Medical School, San Francisco, 1897; member of the American Society of Anesthesiologists; affiliated with Alta Bates Hospital, where she died January 30, aged 74, of coronary thrombosis.

Phillips, Nathan Findley ✠ Mount Lebanon, Pa.; Western Pennsylvania Medical College, Pittsburgh, 1899; died January 20, aged 73, of myocardial infarction and coronary thrombosis.

Radabaugh, Justin Granville, Creswell, Ore.; Chicago Homeopathic Medical College, 1904; died January 23, aged 80.

Radin, Herman Theodore, New York; Columbia University College of Physicians and Surgeons, New York, 1902; died January 16, aged 72, of coronary thrombosis.

Ratcliff, A. Lonzo, Kingman, Ind.; Illinois Medical College, Chicago, 1905; member of the American Medical Association; died in St. Elizabeth Hospital, Lafayette, January 25, aged 78, of acute myocardial infarction while recovering from a fractured vertebra as the result of a fall.

Rategan, Edward Harold, Oak Park, Ill.; University of Illinois College of Medicine, Chicago, 1913; member of the American Medical Association; served as medical examiner for the Illinois Industrial Commission; formerly member of the Golden Gloves medical staff and long time associate in amateur sports conducted by the Chicago Tribune Charities; died in the Veterans Administration Hospital, Hines, Ill., January 19, aged 59, of cerebral accident.

Reck, John Arthur, Oklahoma City; Marion-Sims College of Medicine, St. Louis, 1893; member of the American Medical Association; formerly on the faculty of the University of Oklahoma School of Medicine; died recently, aged 83, of carcinoma.

Reichley, Elmer Jacob ✠ Herington, Kan.; University Medical College of Kansas City, 1906; served during World War I; died recently, aged 75, of coronary thrombosis and arteriosclerosis.

Reud, William Robert ✠ Oakland, Calif.; College of Physicians and Surgeons of San Francisco, 1908; died January 28, aged 82.

Riddle, Mary Adeline, Los Angeles; Northwestern University Woman's Medical School, Chicago, 1893; the Hahnemann Medical College and Hospital, 1894; died January 23, aged 85, of generalized arteriosclerosis.

Ruder, Jacob Arthur, McClure, Ohio; Cleveland Homeopathic Medical College, 1899; for many years member of the school board; on the staff of the S. M. Heller Memorial Hospital, Napoleon; died in Napoleon January 14, aged 81, of arteriosclerosis and chronic nephritis.

Runkle, Herman Abraham, Toledo, Iowa; Rush Medical College, Chicago, 1901; at one time practiced in Lowden, where he was health officer, member of the school board and a director of the Lowden Savings Bank; member of the city council and a member of the board of directors of the First National Bank of Toledo; died in Deaconess Hospital, Marshalltown, January 21, aged 76, of cerebral hemorrhage.

Ryals, William Mann, Ashford, Ala.; Atlanta Medical College, 1887; died January 10, aged 87, of cardiac decompensation and arteriosclerosis.

Sadler, Leroy Huskins, Oklahoma City; University of Oklahoma School of Medicine, Oklahoma City, 1929; associate professor of gynecology at his alma mater; specialist certified by the American Board of Obstetrics and Gynecology; served during World War II; member of the American Medical Association; fellow of the American College of Surgeons; consulting gynecologist, Bone and Joint Hospital; affiliated with University Hospital, Wesley Hospital, St. Anthony Hospital and Mercy Hospital, where he died January 17, aged 46, of cerebral hemorrhage.

Schachner, Hermann Gilbert ✠ Long Beach, Calif.; University of California Medical School, San Francisco, 1946; served during World War II; affiliated with the Veterans Administration; died in the Veterans Administration Hospital January 27, aged 32.

Seid, Sidney Elias, Mountainair, N. M.; Jefferson Medical College of Philadelphia, 1933; died recently, aged 41, of acute coronary occlusion.

Shaffer, Harry Abraham ✠ Williamstown, Pa.; Jefferson Medical College of Philadelphia, 1904; past vice president of Dauphin County Academy of Medicine; for many years medical director of Williams Valley Hospital; died January 31, aged 69, of cerebral hemorrhage.

Shanley, William F. ✠ Yonkers, N. Y.; Fordham University School of Medicine, New York, 1921; affiliated with Yonkers Professional Hospital; died January 15, aged 54, of acute coronary thrombosis and arteriosclerosis.

Shirk, Frank Munsin, La Verne, Calif.; Central Medical College of St. Joseph, Mo., 1896; died January 22, aged 79, of carcinoma.

Shores, Earl Martin ✠ St. Joseph, Mo.; St. Louis University School of Medicine, 1916; an Associate Fellow of the American Medical Association; served during World War I; past president of Buchanan County Medical Society and Buchanan County Tuberculosis Society; affiliated with Missouri Methodist Hospital, where he died January 4, aged 59, of uremia and hypertension.

Sisk, Amplias Owen, Lexington, Ky.; Kentucky School of Medicine, Louisville, 1898; member of the American Medical Association; past president of the Fayette County Medical Society; served overseas during World War I; member of the staffs of Good Samaritan Hospital and St. Joseph's Hospital, where he died January 28, aged 76, of myocardial infarction and coronary sclerosis.

Skinner, Charles Boyd, Hartsville, S. C.; Medical College of the State of South Carolina, Charleston, 1944; member of the American Medical Association; affiliated with Byerly Hospital; served in the medical corps of the U. S. Naval Reserve during World War II; died January 2, aged 30.

Slater, John H., Los Angeles; College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, 1898; died February 2, aged 85.

Smith, Marvin Farris ✠ Atlanta, Ga.; Atlanta College of Physicians and Surgeons, 1913; died January 30, aged 71, of cardiac infarction and coronary sclerosis.

Spaulding, Albert Lee, Charleston, W. Va.; Meharry Medical College, Nashville, Tenn., 1917; served as assistant city health commissioner and as county public health physician; died in St. Francis Hospital January 7, aged 59, of myocarditis, hypertensive heart disease and cerebral hemorrhage.

Stevenson, Hyrum S., Salt Lake City; University of Pennsylvania School of Medicine, Philadelphia, 1922; member of the American Medical Association; on the staff of the Latter Day Saints Hospital; died January 12, aged 74.

Stirewalt, Henry Walter, Concord, Calif.; Medical Department of the University of California, San Francisco, 1894; one of the founders of the Concord Hospital; died recently, aged 81, of lobar pneumonia.

Stokes, William L, Buckner, Ark. (licensed in Arkansas in 1903); for many years county coroner; died in LaFayette County Memorial Hospital, Lewisville, January 15, aged 79, of injuries received in an automobile accident

Storm, Arthur B. ✠ Windsor, Ill.; Barnes Medical College, St. Louis, 1898; died January 24, aged 79, of pneumonia.

Strickland, Edward F., Winston-Salem, N. C.; University of the City of New York Medical Department, 1887; past president of the Forsyth County Medical Society; member of the American Medical Association; for two terms member of the Forsyth County Board of Commissioners; first health officer of Forsyth County; died January 20, aged 87, of heart disease and diabetes mellitus.

Sykes, Roy Wilkinson, Hamburg, Iowa; Rush Medical College, Chicago, 1902; served as health officer of Hamburg; died in Hamburg Hospital January 26, aged 74, of carcinoma of the bone.

Taylor, Clarence W. T. ✠ Duluth, Minn.; Northwestern University Medical School, Chicago, 1900; for many years assistant city health officer; acted as epidemiologist for Duluth; died recently, aged 76, of acute lymphatic leukemia.

Thayer, Claud Boullts ✠ Gainesville, Texas; Georgia College of Eclectic Medicine and Surgery, Atlanta, 1905; affiliated with Gainesville Sanitarium, where he died January 22, aged 72.

Thomas, Margaret Louise, Welch, W. Va.; Meharry Medical College, Nashville, Tenn., 1944; interned at Brewster Hospital in Jacksonville, Fla.; assistant health officer for McDowell County; died in St. Mary's Hospital, Bluefield, January 19, aged 30.

Thompson, Robert Taylor ✠ Cincinnati; University of Pittsburgh School of Medicine, 1941; specialist certified by the American Board of Internal Medicine; member of the Central Society for Clinical Research and the American Association for the Advancement of Science; assistant professor of medicine and assistant to the dean at the University of Cincinnati College of Medicine; assistant attending physician, Cincinnati General Hospital, where he died January 22, aged 36, of carcinomatosis.

Tibbetts, Mark Hopkins, Duluth, Minn.; Johns Hopkins University School of Medicine, Baltimore, 1917; specialist certified by the American Board of Orthopaedic Surgery; member of the Clinical Orthopaedic Society, American Medical Association and the American Academy of Orthopaedic Surgeons; served during World Wars I and II; on the staffs of St. Luke's, St. Mary's and Miller Memorial hospitals; died in Chicago January 27, aged 61, of coronary thrombosis.

Tilly, Wilton Paul Duncan ✠ New Iberia, La.; University of Nashville (Tenn.) Medical Department, 1911; fellow of the International College of Surgeons; past vice president of the Louisiana State Medical Society; owner of Tilly's Clinic Hospital; died January 19, aged 64, of acute cardiac failure.

Todd, Mark Fischer, Springfield, Ill.; University of Michigan Medical School, Ann Arbor, 1942; member of the American Medical Association; served in the U. S. Naval Reserve during World War II; later served in the medical corps of the U. S. Navy, resigning in June 1947 as a lieutenant; died in St. John's Hospital January 29, aged 35.

Torrence, George Abbitt ✠ Hot Springs, Va.; Medical College of Virginia, Richmond, 1914; served during World War I; died in Fort Lauderdale, Fla., January 11, aged 58, of myocardial infarction and coronary arteriosclerosis.

Turner, James, La Pryor, Texas; Ohio Medical University, Columbus, 1905; died recently, aged 76.

Tybout, Richard Raymond ✠ New Castle, Del.; University of Pennsylvania Department of Medicine, Philadelphia, 1887; served during World War I; consultant in ophthalmology at Delaware Hospital, Wilmington, where he died January 29, aged 85, of coronary thrombosis and arteriosclerotic heart disease.

Utz, David Willis ✠ Rockville Centre, N. Y.; Howard University College of Medicine, Washington, D. C., 1933; specialist certified by the American Board of Pediatrics; member of the American Academy of Pediatrics; served on the staffs of the Jamaica Hospital and Queens General Hospital in Jamaica; died in February, aged 41.

Valentine, Lelius Paul Antoine, Racine, Wis.; Kentucky School of Medicine, Louisville, 1896; died January 27, aged 78.

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Vandivier, Henry Rufus, Terre Haute, Ind.; Medical College of Indiana, Indianapolis, 1898; member of the American Medical Association; past president of Vigo County Medical Society; on the staff of Union Hospital; died in St. Anthony's Hospital January 20, aged 81, of coronary thrombosis.

Veit, Alfred Walter ✙ Wapakoneta, Ohio; University of Michigan Medical School, Ann Arbor, 1922; served during World War I; recently named member of the medical advisory committee of the Auglaize County Draft Board; county coroner and city health officer; affiliated with St. Rita's and Memorial hospitals in Lima; died January 4, aged 54, of coronary heart disease.

Wagner, George Garfield, Buffalo; University of Buffalo School of Medicine, 1904; member of the American Medical Association; on the staff of Buffalo General Hospital; died February 2, aged 70, of arteriosclerotic heart disease.

Wakeman, Allie Hoyt, Fort Dodge, Iowa; Keokuk Medical College, College of Physicians and Surgeons, 1901; member of the American Medical Association; for many years school physician; affiliated with St. Joseph Mercy Hospital and Lutheran Hospital, where he died February 6, aged 76, of coronary occlusion.

Walker, John Riley, Enid, Okla.; Keokuk (Iowa) Medical College, College of Physicians and Surgeons, 1904; past president and for many years secretary of the Garfield County Medical Society; served during World War I; on the medical examining board for the Garfield County Selective Service board during World War II; died January 27, aged 75, of cardiovascular renal disease.

Ward, Clarence Vincent ✙ Peoria, Ill.; St. Louis University School of Medicine, 1919; affiliated with St. Francis Hospital, where he died January 27, aged 55, of cerebral hemorrhage.

Ward, Donald Slusher, Pittsburgh; Jefferson Medical College of Philadelphia, 1923; member of the American Medical Association; died January 10, aged 52, of cerebral hemorrhage.

Warren, Arthur Fulton, Longview, Wash.; Stanford University School of Medicine, San Francisco, 1923; specialist certified by the American Board of Otolaryngology; served during World War II; affiliated with Cowlitz General and St. John's hospitals; died recently, aged 53, of coronary thrombosis.

Webster, Ben, St. Cloud, Fla.; Georgetown University School of Medicine, Washington, D. C., 1900; died in Kissimmee (Fla.) Hospital January 4, aged 72, of cerebral hemorrhage and hypertension.

Weeks, James Louis, Perry, Fla.; Medical College of the State of South Carolina, Charleston, 1907; died January 30, aged 72, of diabetes mellitus.

Wehrbein, Heinrich Louis ✙ Brooklyn; Indiana University School of Medicine, Indianapolis, 1925; specialist certified by the American Board of Urology; member of the American Urological Association; fellow of the American College of Surgeons; affiliated with Brooklyn and Lutheran hospitals; urological consultant, St. John's Hospital; died January 9, aged 61, of bronchogenic carcinoma.

Weil, Julius, Kew Gardens, N. Y.; Medizinische Fakultät der Universität, Wien, Austria, 1909; member of the American Medical Association; died February 16, aged 67, of heart disease.

Weissbach, William Herman Jr., Forest Hills, Pa.; Temple University School of Medicine, Philadelphia, 1937; member of the American Medical Association; served during World War II; on the staff of Braddock (Pa.) Hospital; died January 11, aged 38.

Westcott, Clinton Stevens ✙ Providence, R. I.; Columbia University College of Physicians and Surgeons, New York, 1901; past president of the Providence Medical Association; served during World War I; for many years affiliated with the Rhode Island Hospital; died in the Veterans Administration Hospital January 8, aged 73, of hypertension and cardiovascular disease.

Weygandt, Steven Franklin, St. Louis; St. Louis College of Physicians and Surgeons, 1917; also a lawyer; died in the Jewish Hospital February 5, aged 66, of heart disease.

Whitacre, R. Frederick, Wayne, Ohio; Eclectic Medical Institute, Cincinnati, 1901; for many years member of the county health board; died in Mercy Hospital, Toledo, January 17, aged 77, of carcinoma.

Williams, Mantle Birt, Canton, Ohio; Meharry Medical College, Nashville, Tenn., 1921; member of the American Medical Association; on the courtesy staff of Aultman Hospital, where he died January 11, aged 58, of traumatic cerebral concussion and subarachnoid hemorrhage.

Wilson, William Walsh, Montclair, N. J.; Hahnemann Medical College and Hospital of Philadelphia, 1905; died January 27, aged 82, of cerebral hemorrhage.

Wynkoop, Roy Baldwin ✙ Ashtabula, Ohio; born in Chemung, N. Y., April 18, 1885; Cornell University Medical College, New York, 1908; past president of the Ashtabula County Medical Society; at one time ship's surgeon on ocean vessels in the South American trade; a captain in the 323rd Field Artillery in World War I and saw active duty in France and with the Army of Occupation in Germany; served as city health commissioner; affiliated with Ashtabula General Hospital, where he died January 3, aged 65, of chronic interstitial cystitis.

Yeager, Norton Reeme, Chicago; University of Pennsylvania Department of Medicine, Philadelphia, 1890; died February 4, aged 81, of arteriosclerotic heart disease.

Zahn, Arthur, Brooklyn; University and Bellevue Hospital Medi-College, New York, 1926; member of the American Medical Association; died January 28, aged 48.

Zalesky, Wililam John ✙ Medical Director, Captain, U. S. Navy, retired, La Jolla, Calif.; University of Michigan Department of Medicine and Surgery, Ann Arbor, 1903; appointed a lieutenant (jg) in the medical corps of the U. S. Navy in April 1899 and, after 44 years' service, was retired from active duty in 1943; served three tours of duty in Washington, D. C.; fellow of the American College of Surgeons; died January 15, aged 71, of heart disease, in Barranquilla, Colombia, South America, while traveling.

Zlatkin, Louis ✙ Detroit; University of Michigan Medical School, Ann Arbor, 1935; specialist certified by the American Board of Dermatology and Syphilology; member of the American Academy of Dermatology and Syphilology; on the staff of the Florence Crittenton Hospital; died January 30, aged 40, of carcinoma of the colon.

Zlatovski, Michael Leibovich, Duluth, Minn.; University of St. Vladimira Faculty of Medicine, Kiev, Russia, 1913; member of the American Medical Association; died in St. Mary's Hospital January 15, aged 70, probably of acute coronary occlusion.

DIED WHILE IN MILITARY SERVICE

Miller, Jesse Walter ✙ Medical Director, Captain, U. S. Navy, Denton, Neb.; born April 14, 1903; University of Nebraska College of Medicine, Omaha, 1927; commissioned a lieutenant (jg) in the medical corps of the U. S. Navy on June 7, 1927; in 1944 was executive officer of Naval Base Hospital no. 12 in Southampton, England; for outstanding service while at this station received a Letter of Commendation from the Secretary of the Navy; assigned as medical officer on the staff of the Commander, Naval Forces, European area, and still later as medical officer on the staff of the Commander, Naval Forces, Germany; in 1942-1943 served as executive officer of the Naval Dispensary, Washington, D. C.; executive officer of the U. S. Naval Hospital, Charleston, S. C., where he died February 2, aged 47, as a result of a fire which destroyed his quarters on the hospital grounds.

Coats, Daniel Tedford, San Francisco; University of Kansas School of Medicine, Kansas City, 1950; served 21 months in Aviation Cadet Training with the Air Force during World War II; first lieutenant in the medical corps of the Organized Reserve Corps; intern, Letterman Army Hospital; died January 18, aged 27, of cerebral hemorrhage.

GOVERNMENT SERVICES

ARMY

Headquarters Selective Service System

Washington, D. C.
April 12, 1951.

Operations Bulletin No. 30

Subject: Special Registrants Completing Internships or Residencies in June 1951

1. A doctor of medicine or dentistry can perform his service in the armed forces with the least inconvenience to himself and with the least dislocation of medical programs in communities and hospitals immediately following the end of his period of internship or residency. Most internships and residencies are terminated on or about the 30th of June of each year.

2. The Office of the Surgeon General of the Army has informed this Headquarters that orders placing reserve officers on active duty must be obtained at least thirty (30) days prior to the date of entry upon active duty. After a special registrant applies for a commission some time is required to complete his processing. In order that a special registrant who desires to enter military service immediately after completion of his internship or residency training may be in a position to do so without loss of time while awaiting the completion of his processing for a commission and receipt of orders to active duty, he should apply for a commission at least two months before he is to complete his training.

3. The Office of the Surgeon General of the Army has therefore requested that local boards be informed that special registrants in the first priority now serving internships and residencies in hospitals who are in Class I-A or Class I-A-O, or who are now deferred and who the local boards expect to make available and reclassify in Class I-A or Class I-A-O by June 30, 1951, should be advised to apply for a commission on or before May 1, 1951. Such registrants who receive reserve commissions will not be ordered to active duty until July 1951, thus giving them time to complete their internship or residency training.

4. Each special registrant in the first priority who has been physically examined and found acceptable, and who is in Class I-A or Class I-A-O, or who is now deferred and is to be reclassified into Class I-A or Class I-A-O by June 30, 1951, should be advised by the local board to apply for a commission by letter or telegram addressed to the Surgeon of the respective Field Army. Each such special registrant who has been classified in a deferred classification and has not been physically examined should be forwarded for physical examination in accordance with the provisions of Part 1650 of the regulations as soon as practicable after being reclassified into Class I-A or Class I-A-O.

5. The name and selective service number of each special registrant in the first priority who has his classification changed to Class I-A or Class I-A-O, and who has been found acceptable for a commission should be submitted by the State Director of Selective Service to the Surgeon of the appropriate Field Army, regardless of the original answer which such special registrant may have made to Item 30 on DD Form 390. The Surgeon will communicate with such special registrants respecting their application for commissions.

LEWIS B. HERSHEY, *Director.*

Awards and Commendation.—The Silver Star was recently awarded to Major Edwin L. Overholt, Chicago, Illinois. The citation reads in part as follows:

"Major Edwin L. Overholt, 060030, Medical Corps, United States Army, distinguished himself by conspicuous gallantry in action at Osan and Ansong, Korea, during the period July 5 to July 7, 1950. In rugged mountainous terrain with improvised facilities and under constant enemy fire, Major Overholt undoubtedly saved the lives of many wounded soldiers. His care of battlefield casualties was characterized by exceptional skill, calmness and deep personal concern without regard for his own comfort and safety. When forced to withdraw from Osan Hill, Major Overholt assisted in carrying the wounded over mountainous terrain for a distance of about forty miles. During this journey, he remained behind with litter cases who could not be carried further, satisfying himself that every possible aid had been given to the wounded men before he rejoined the unit. Reaching Ansong, Major Overholt, without food or rest, assisted with an emergency operation on an American soldier: and then he undertook to treat the wounded men of a unit that had lost its surgeon in combat. His professional skill and selfless devotion in caring for the wounded with complete disregard for the hazards of battle exemplify conduct that is in keeping with the highest traditions of the military service."

Major Overholt graduated from the University of Iowa School of Medicine in 1948.

VETERANS ADMINISTRATION

Residencies in Psychiatry.—Residencies in psychiatry are available at the United States Veterans Administration Hospital, Hines, Ill., beginning July 1, 1951 for a period of three years. The residency program is under the direction of the Department of Psychiatry, University of Illinois. The hospital is within commuting distance of all other psychiatric facilities in the Chicago area. The training is fully accredited by the American Board of Psychiatry and Neurology.

Personal.—Dr. Willis E. Manney has been appointed manager of the new 500 bed Veterans Administration hospital nearing completion in Kansas City, Mo. Dr. Manney has been chief medical officer of the VA Center in Wadsworth, Kan., since September 1946. He has been with VA since 1931, except for four years during World War II when he was on active military duty.

MISCELLANEOUS

Three Day Mine Safety Contest.—A nationwide three day first aid and mine rescue contest has been discussed and committees named. The Bureau of Mines is one of the sponsors of the event. Representatives of several state mining departments, coal and metal mine trade associations, mine workers organizations and the Bureau of Mines tentatively fixed October 3-5 as the dates and Washington, D. C., as the place for the contest. Two cities —Columbus, Ohio, and St. Louis—were chosen as alternates in the event the contest cannot be staged in Washington. The interest of the Bureau of Mines in the national first aid and mine rescue contest lies in the fact that for four decades the Bureau has carried on a broad program of instruction in first aid, accident prevention and mine rescue in the mining and related industries of the nation. Thousands of mine officials and workers have been trained in Bureau methods.

Medical Educators Go to Japan.—Acting on behalf of the Department of Defense and under the direction of the Unitarian Service Committee, a team of 12 medical educators will leave New York May 9 for Japan to try to bring teaching methods in that country in line with those of the United States. The team will examine teaching and research methods in Japanese medical schools and direct lectures and demonstrations to students and staff members. The team of scientists is comprised of specialists in different medical fields. The schools represented on the team are Duke, Harvard, Yale, Stanford, Michigan, California, Washington University, Wayne, Emory and the Medical College of Georgia. They will spend two months in Japan. Previously two other teams were sent to Germany and Czechoslovakia.

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FOREIGN LETTERS

PARIS

Mode of Endocrine Action of Salicylates and Gentisates.—While studying the toxicity of various salicylic and gentisic compounds, C. Champy and M. Demay noted a curious alteration of the spleen: pyknosis, followed by a lysis of lymphoid nodules, reduction of the white pulp and reappearance of megakaryocytes. Further study proved that these alterations are due to the gentisic or salicylic radical and not to various bases with which they may be combined. Impressed by the same phenomena as those reported by Seyle and his co-workers as existing in the action of cortisone, the authors were thus led to the study of adrenal glands. These glands showed after administration of these drugs, a marked hypertrophy (of about a third) and, histologically, on all the external part of the cortex a characteristic appearance with a dark band of small chromophilic cells; modifications described by Seyle following the administration of pituitary adrenocorticotropic hormone (ACTH). In control rats subjected to this medication, the modifications of the cortex and the hypertrophy were similar to those produced by salicylates and gentisates. It appears that these medicaments act exactly like ACTH and very likely by provoking a secretion of cortisone, which the authors prove by other arguments: Ascorbic acid contained in the adrenals diminished by one third an hour after administration of a single large dose of salicylate, and the diminution of the cholesterol in the cortex is evident. Cortisone was given to a series of control rats for four days. These showed a characteristic splenic, but no adrenal, modification. The authors assume that salicylates do not act directly on the adrenals or the spleen but on the hypophysis, inducing the production of ACTH.

Death of Professor Balthazard.—Professor Balthazard, dead at 78, was the master of French legal medicine. He was a member of the National Academy of Medicine and inaugurated the Institute of Legal Medicine. He published numerous works in this branch of medicine, among which are the researches on carbon dioxide and alcohol in the blood, on methemoglobin and cyanmethemoglobin. During the occupation of France by Nazis, Professor Balthazard played a great part in the resistance of the members of the French medical profession.

SPAIN

Treatment of Rheumatoid Arthritis, Asthma and Collagen Diseases with Nitrogen Mustard.—Jiménez Diaz, professor of internal medicine and director of the Institute of Medical Research in the University of Madrid, Merchante, Perianes, López Garcia and Puig Leal have treated rheumatoid arthritis, asthma and collagen diseases with nitrogen mustard. Improvement was very great in nine out of 14 cases of rheumatoid arthritis. The effects of the treatment were apparent after two or three injections of the usual dose (0.1 mg. per kilogram of body weight). Auricular mobility increased, and inflammatory infiltration and fever decreased. However, the erythrocyte sedimentation rate did not change. The improvement continued six months after treatment had been discontinued in several patients. Seven of the eight patients with asthma showed immediate improvement. In five of the seven patients the improvement lasted three months after treatment had stopped. Beneficial results were also obtained in psoriasis, periarteritis nodosa, uveochoroiditis and thromboangiitis obliterans.

Fecal Histamine and Allergy.—Histamine is either absent or is found only in a small quantity in the feces of normal persons. Arjona, Perianes, Lorente, Aguirre and Jiménez Diaz found amounts of histamine that at times reached 250 gamma per gram of feces in many allergic persons (suffering from asthma or from urticaria). Histamine formation was demonstrated by incubation with histidine of feces of allergic patients. No histamine was formed in the feces of normal persons. The addition of sulfonamides to the feces greatly increased the quantity of histamine that is formed. The histamine was identified by pharmacologic and chemical tests. The feces of asthmatics treated with fever therapy, who as a result are symptom free, loses the propensity to form histamine. However, the addition of normal feces to the feces of the asthmatic does not prevent the formation of histamine in the feces of the latter. The role of histamine that is formed in the intestine in the production of the allergic symptoms is still unknown.

Experimental Nephritis.—Experimental nephritis produced by alloxan, uranium, safranine and the antikidney serum of Masugi has been studied by Jiménez Diaz, Morales, Picatoste, López Garcia, Roda, Castro and Villasante. The phases of nephritis and the different aspects of renal regeneration were analyzed in the first phase of the study. It was demonstrated that the aforementioned toxins primarily act on the endothelium and the glomeruli; later, the proximal tubules are affected. The obstruction of the distal tubes by cellular debris and intraluminal exudates is an important factor, leading to chronic nephritis. In relation to these problems, the renal enzyme systems were studied by Jiménez Diaz, Picatoste and Villamil. Hypophysectomy causes a decrease in deaminizing activity and of glutaminase. Adrenalectomy hardly affects glutaminase but results in a decrease in phosphatase and in deaminizing activity. These facts led Jiménez Diaz to establish the concept of renal dysfunction associated with purely metabolic changes of renal function.

Microprecipitins in Allergy.—Segovia, Arjona, Jiménez Diaz and Alés did 1,086 quantitative determinations of precipitin antibodies in the blood of a large number of allergic patients. The reaction that was obtained is specific and is due to the presence of a microprecipitin antibody that is distinct from the blocking antibody and from the precipitin that is produced in animals by the injection of foreign proteins. A microprecipitin reaction was obtained only experimentally in animals (rats) in whom anaphylactic shock was not successful, or in other animals (guinea pigs, rabbits) with antigens, such as house dust in the case of asthmatics, that are not capable of producing anaphylactic shock. The microprecipitin is thermostabile and is preserved in refrigerated blood serum for several days.

Subacute Endocarditis.—The study of patients with the classic picture of subacute endocarditis but with negative blood cultures has been continued. Even the culture of the valves after autopsy is negative in these cases. In addition, some symptoms and signs exist that differ from those of the classic picture of subacute endocarditis. Renal symptoms are usually predominant, splenomegaly is prominent and leukopenia exists. Jiménez Diaz and Arjona, cultured the bone marrow of these patients, and obtained a very slow growing, polymorphous organism that could be related to the Corynebacterium. They called it C. endocarditis. Culture of the bone marrow became negative in cases clinically cured with large doses of penicillin. The organism was not found in the cardiac valves.

Neurochemical Regulation of Arterial Pressure.—Jiménez Diaz, Barreda, Molina, Souto and Alcalá demonstrated by cross circulation experiments that the hypertensive response produced by the stimulation of the central end of a sectioned vagus nerve is in part dependent on a humoral mechanism. The authors' thesis is that the pressor substance issues from the arterial wall itself and is activated by an agent present in the plasma. A similar effect is observed in regard to the coagulability of the blood, namely, that, the coagulability increases after the stimulation of the central segment of the vagus nerve, provided always that the artery from which the blood is taken has not been denervated.

The items in these letters are contributed by regular correspondents in the various foreign countries.

Experimental Lathyrism.—Jiménez Diaz, Vivanco and Palacios confirmed the reports that a paralytic picture could be obtained in rats through the ingestion of chick peas as well as by the administration of Lathyrusodoratus. Severe scoliosis, which increased until the medulla was affected, were produced in these animals. Scoliosis could be prevented by the administration of methionine or by a factor present in hepatic extracts which they call the CH factor.

ITALY

Congress of Urology.—The Second Congress of the Society of Urology of Latin Mediterranean countries held at San Remo was attended by eminent Italian, French and Spanish specialists. The treatment of anuria was the subject of discussion. Prof. Alcalá Santaella pointed out that treatment should be closely related to the type of anuria. In excretory anuria it is necessary to remove the cause; in calculous anuria renal pelvic lavage produces satisfactory results. This procedure has been practiced and perfected by Professor Chauvin and his school. Intravenous administration of procaine hydrochloride is also of value.

The modern means of treating reflex anuria include peritoneal lavage, recommended by American authors, and the artificial kidney.

Dr. Lucena classified anuria into secretory and excretory anuria, subdividing the first category into prerenal and renal anuria. In cases of prerenal anuria, resulting from diseases of the liver, the digestive tract or the circulatory system, it is necessary to combat dehydration with fluids, without exceeding, however, 23 liters in 24 hours. He recommends rectal administration, drop by drop, with an apparatus that automatically regulates the introduction of the fluid in accordance with absorption. He recommends blood transfusion in cases of posthemorrhagic anuria. Acidosis is neutralized by administration of sodium bicarbonate solution. In cardiac patients, adrenal cortex hormones should be used in addition to digitalis and strophanthin preparations. In renal anuria associated with acute processes that impair intrarenal circulation (e. g., glomerulonephritis, necrotizing nephrosis due to poisoning or to the administration of sulfonamide compounds) Dr. Lucena performs paravertebral block or gives intravenous injections of procaine hydrochloride. Anurias resulting from irreversible acute renal insufficiency should be treated with peritoneal dialysis and the artificial kidney. In anurias due to chronic renal processes, one should attempt renal pelvic lavage and, in extreme cases, renal decortication or nephrostomy. Temporary recovery of the patient may sometimes be obtained with these methods.

Professor Chauvin, president of the Society of Urology of the Latin Mediterranean countries, discussing anuria in general, stated that "lethargy" of the kidneys may be a sequel of painful sensations in the renal pelvis and the ureter. It may subside suddenly and the kidney immediately resumes function, indicating the absence of anatomic lesions and the reflex nature of the lethargy. This phenomenon seems to be due to a spasm of the papillary sphincters and ceases after anesthesia of the renal pelvis.

Professor Pisani, after presenting some considerations on anuria, summarized the modern therapeutic concepts with regard to this form of disease, as follows: 1. There are different types of anuria and consequently therapy varies. 2. The determination of the type is not always easy and rapid. 3. Early institution of treatment is necessary; unfortunately, many cases of anuria come to the attention of the urologist too late. 4. Vascular or excretory spasm, especially of the musculature of the calix renalis, is frequent and produces anuria. 5. When anuria is still reversible, the most efficacious and lasting therapeutic measures are anesthesia combined, if possible, with the removal of the obstructing element, and general supportive measures. Antibiotics may be administered in order to control primary or secondary infection. Treatment may also include decapsulation and, eventually, nephropyelostomy.

Pollinosis.—At the First National Congress of Allergy, held in Florence under the chairmanship of Professor Frugoni, clinician of Rome, Prof. Umberto Serafini presented a report on pollinosis and discussed results obtained at the Medical Clinic of Rome. The report was preceded by a botanic survey by Professor Gola, of Padua. The most important conclusions of the two reports are as follows:

From the botanical viewpoint, pollinosis generally depends on vegetable species whose flowers are of anemophilous type; the most important among them is the Graminaceae family. The pollen count reaches its peak during midspring. Pollen from Parietaria officinalis is almost always present in Italy.

Professor Serafini reported the results of studies of 1,343 cases of pollinosis. A positive skin reaction was obtained in 65.7 per cent of the cases. There is greater incidence of asthma in pollinoses caused by Urticaceae, than by Graminaceae. The specific densensitization treatment was effective in 85 per cent of the cases; antihistaminic drugs proved useful in 70 per cent. Combination of the two methods is, at present, the therapy of choice for pollinosis.

ISRAEL

Chemical Lobotomy.—Since Egas Moniz devised lobotomy in 1936 many trials have been made to improve the disadvantages of this method. Such a trial was made by Prof. Felix Mandl. The results are reported in the *Acta Medica Orientalia* (vol. 10, no. 1, 1951). Mandl treated 16 patients (four with psychoses and 12 with carcinoma) by infiltration therapy of the frontal lobe, injecting 10 to 13 cc. of a 1 per cent procaine solution. As the injection point he chose the spot described by Scarff for operative lobotomy (2 cm. before the coronary suture and 3 cm. laterally from the midline). At this spot the os frontale was trepanned at an oblique angle, and the needle directed in an angle of 45 degrees toward the superior tegmen of the orbita. After 8 to 9 cm. there occurs a stop which indicates the correct position of the needle. As the needle is withdrawn, 10 to 13 cc. of a 1 per cent procaine solution or a 6 per cent phenol solution is injected.

For evaluation of chemical lobotomy, 12 patients with carcinoma who described their pains as intolerable were chosen. Results in four cases could be called excellent and in four good. In these eight, pains fully disappeared or to the extent that they could be controlled by the usual analgesics. The other four patients improved only temporarily or not at all. Side effects noted were temporary apnea with cyanosis, which occurred immediately after the procaine injection. These conditions, however, could be influenced by analeptics and oxygen. Usually the blood pressure was reduced after the injection, the pulse rate increased and the pupil on the treated side dilated. Three patients showed nystagmus 30 minutes after treatment. Depersonalization in slight degree took place in only one patient. The recurrence of phantom-like pain reactions was remarkable: pains resulting from the tumor itself disappear immediately after the infiltration, while sensations of pain occur in places not connected with the diseased organ. Thus, a patient with an inoperable cancer of the neck experienced pain from the region of the mandibular nerve, while a patient with carcinoma of the bronchus loses his local pains and experiences instead pains in the abdomen. Three patients have died. Postmortem examination disclosed cystlike degenerations in the brain, in the area where the needle had penetrated. Mandl believes that chemical lobotomy for unbearable pains in tumors will attain a place in therapy.

Psychosociology of the Immigrant; Henrietta Szold Prize.—The Henrietta Szold prize, distributed yearly by the Tel Aviv Municipality, was divided in February among four scientists who published works dealing with public health and social hygiene: Prof. H. Sadowsky, who reported about women's diseases; Dr. A. Weinberg, author of "Psychosociology of the Immigrant," and Dr. Sarah Bawly and Dr. G. Cydrovitz, who conducted investigations about nutrition of the Jewish population in towns and in the country.

Dr. Weinberg's investigations have dealt with problems connected with the adjustment of the Jewish immigrants into Palis-

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tine, or Israel. The investigations were made with immigrants from Holland who came to Palestine before 1939. Altogether 280 persons (134 men and 146 women) were interrogated by questionnaires. All persons were older than 18 years and resident in Palestine for at least three years. The composition of the investigated group was such as might be considered to form a representative sample. The author conducted the interrogations in person and in nearly all the cases in the home of the informant. The 400 questions were arranged and asked in such a way as to create a contact between the informant and the interrogator similar to that known as "transference" in psychoanalysis. There were in the questionnaire items relating to personal status, life history prior to immigration, conditions of life in Palestine, state of health, profession, financial conditions, culture and feeling of being integrated into Palestine. Direct questions, i. e., questions involving self judgment, were avoided as far as possible. The method used allowed a combination of statistical and casuistic evaluations of the data. Every variable investigated (such as the degree of "feeling at home" and knowledge of Hebrew) was qualified by assigning to it values on a 10 point empirical scale. This enabled an investigation into the relation between the variables by ordinary statistical methods. Each immigrant was given a score for his measure of success in Palestine as the basis of his case history. This index correlated $r = 0.80 \pm 0.02$ with the self evaluation of the immigrant as to his adjustment.

The results can be summed up in such a way that the new immigrant can adjust himself at a satisfying degree to life in the country after three years, but much more time is needed for taking root—at least 10 years. Immigrants under 21 have the best chances to succeed. Those between 40 and 54 succeeded least in taking root. Older persons, however, living with their children show again more satisfactory adjustments. It proved always true that immigrants living together with intimate friends from Europe have the least chances of really getting adjusted to the conditions of the country. A good knowledge of Hebrew is an essential prerequisite of successfully taking root ($r = 0.62 \pm 0.04$). There is a close connection between professional success and the general taking root in the country. Thereby it is not decisive whether the immigrant has the same occupation in Palestine/Israel as in Holland. Striking was the fact that about half the investigated persons (44.2 per cent) felt more nervous than in Holland. This is obviously due to the fact that they could not adjust themselves successfully to the new habits of life. According to the author's experience, one of the main reasons for the frequency of increased nervousness is that they miss their former environment. Latent neurotic behavior may become overt because of the absence of the parental home with which the patient still had a link, or by reason of the fact that the patient is removed from the environment of his native country which gave him his psychological locus standi (father or mother image); i. e., one form or another of a neurosis may break out. The lesser degree of success, on the other hand, increases the chances of a neurosis; there exists, exactly as in so many other cases, an interplay of factors.

The results of these investigations led to the urgent demand for greater attention to mental hygiene in Israel. Meanwhile, a society for mental hygiene has been founded in Israel. There remains, however, the necessity for establishment of a research institute for mental hygiene for further investigation of such problems and their solution. The multiplicity and variety of immigrating groups of population require special care.

Birth and Death Rates.—The birth rate of the Jewish population rose while the death rate dropped during 1950 as compared with 1949, according to statistics just released. The average natural increase in 1950 was 13 per cent higher than in the preceding year. The birth rate went up from 29.94 per 1,000 in 1949 to 32.64 per 1,000 in 1950, while the death rate fell from 6.84 per 1,000 to 6.48 per 1,000. Infant mortality dropped approximately 10 per cent, from 51.71 per 1,000 in 1949 to 46.58 in 1950.

The natural increase during 1950 accounted for 15 per cent of the general population rise. Since the creation of the state it accounted for a 9 per cent increase. In actual numbers the Jewish population increased by more than 500 pesrons daily. At the end of 1950 the Jewish population was 1,203,000, an increase of 189,000 persons.

More than half the Jewish population is concentrated in the Tel Aviv-Jaffa area. The population of the Negev, the southern part of Israel's former desert area, increased by 174 per cent, the greatest growth of any area in the country. The average population increase in all was 25 per cent. The Negev at the end of 1950 had 17,792 Jews—1.5 per cent of the population.

Upper Galilee grew by 52.9 per cent, the Sharon by 46.5 per cent, the Emek by 41.6 per cent and Lower Galilee by 35.5 per cent.

ECUADOR

Amebiasis in Quito.—Amebiasis is one of the most serious public health problems in Quito, a city situated at an altitude of 2,800 meters, and in most of the towns in the Ecuadorian Andes Mountains, because of the poor hygienic conditions in this area. Cases of acute amebiasis occur throughout the year, the incidence of the infection being greater during the rainy season, during which actual epidemics occur. This great incidence is due to (1) drinking of nonpotable water and (2) the transmission by flies of amebas or cysts from the infected soil to the fruits of the season (pears, apples and cherries, for example). During the rainy season, rain washes the dried feces from the soil of many small rural communities in which there are no toilets, and the water becomes infected with amebic cysts and parasites.

Drs. Garcés and Jarrín recently reviewed the records for a 10 year period of the Quito hospitals. In this period, 39,609 stool examinations were made in the hospitals. Endameba histolytica in any of its various forms was encountered in 12,599 instances. Most examinations were made on the feces of patients with symptoms indicating the presence of intestinal parasitosis. The results indicated that in at least 30 per cent of the cases E. histolytica was the causal parasite. Recently a public health law was passed in Ecuador requiring all food sellers to report to an appointed center for stool examination. Dr. García and Jarrín examined the stools of 1,500 food sellers. None had clinical symptoms of intestinal parasitosis; however, the results were positive for intestinal parasitosis in 536 cases. In order of frequency the following parasites were encountered: Trichocephalus 13 per cent, Endameba coli 8 per cent, E. histolytica 7.46 per cent, Trichomona hominis 6.13 per cent, Ascaris lumbricoides 3.06 per cent, Giardia intestinalis 2.86 per cent, Ancylostoma duodenale 1.46 per cent, Endolimax nana 1.33 per cent, Taenia solium 0.6 per cent, Strongyloides stercoralis 0.46 per cent, Balantidium coli 0.33 per cent, Anguillula 0.33 per cent and Chilomastix mesnili 0.13 per cent. All the cases of Ancylostoma infestation were found in vendors from either tropical or subtropical zones.

Dr. Naranjo Vargas did similar studies in rural zones near Quito city in 1948. From examinations of 1,086 persons he found the following order of frequency of the diseases: infantile gastroenteritis 11.5 per cent, infectious and parasitic diseases of the skin 11.3 per cent, helminthiasis (mostly in school children) 6.7 per cent and amebic dysentery 5.4 per cent.

Bronchospasm, Emphysema and Atelectasis.—Dr. Naranjo Vargas, professor at Central University, led a round table on bronchospasm, emphysema and atelectasis in the department of medicine of the university. He reviewed theories regarding the pathogenesis of asthma in man and of anaphylactic and histamine shock in some animals. He cited the conclusions of Pasteur Vallery-Radot and his associates, namely, that edema of the bronchial mucous membrane is the predominant factor causing the manifestations in allergic asthma and in anaphylactic shock of the guinea pig. Dr. Vargas referred to his own laboratory investigations, pointing out that the chief respiratory tract effects during histamine shock in the rabbit, cat and dog are edema and bronchial secretions, while bronchoconstriction is the predominant phenomenon in the guinea pig. Using new techniques, he has proved that, even in species in which edema is the predominant phenomenon, bronchial spasm, reversed by sympathomimetic drugs is also produced. On the other hand, he discovered that partial obstruction of either the trachea or the large bronchus, until the animal died of anoxia, resulted in atelectasis instead of emphysema.

Institute of Nutrition.—The Institute of Nutrition was founded in Quito on January 30, 1951. The President of the Republic and several ministers and representatives from the medical, hygienic, sanitation and social welfare institutions were present at the ceremonies. On the special invitation of the government of Ecuador, Drs. Benjamin Horning and Robert Harris attended the ceremonies. They were decorated by President Plaza in recognition of their work. The construction and equipment of the building were made possible by these two doctors with the participation of some North American institutions, especially the Kellogg Foundation, Massachusetts Institute of Technology and the Rockefeller Foundation.

Personal Items.—Several physicians attending the medical meeting held in New Orleans during the second week of March 1950 were invited by the medical profession of Ecuador to make a good will visit to Ecuador. The following physicians and their wives arrived at Quito on March 17: Drs. L. Fortier, T. Simpson, A. Antweil, J. Siegel, W. Fountain, W. G. Gilsderf, E. Keith, M. A. Sonderegger, P. B. Salatich and F. Temple Brown. Among the festivities was a banquet given to the visitors by the members of the Medical Federation of Ecuador. Dr. C. Andrade Marín, former minister of social service, hygiene and public health and director of the medical department of the social insurance body, is at present in Geneva as a member of the social committee of the United Nations representing the government of Ecuador. Dr. Miguel A. Echeverría has been named director of the Hospital Eugenio Espejo of Quito. Dr. Carlos Andrade Marín has been named delegate of Ecuador before the Social Commission of the UNO (Comisión Social de la ONU).

BRAZIL

Tuberculosis in the Brazilian Negro.—Dr. Geraldo Franco, medical director of the Santo Antonio Tuberculosis Sanatorium, reported the results of a study on 5,000 clerical workers of the city of São Paulo examined during the period 1935-1948, when the author was physician of the Instituto dos Bancarios, an institution devoted, among other things, to securing medical care, retirement and pensions for bank employees. Out of the total number of persons examined, 4,805 (961 per thousand) were tuberculin positive (Pirquet) and 657 (131 per thousand) had active pulmonary tuberculosis. In the latter group, lesions were minimal in 416, moderately advanced in 57 and very advanced in 94 and 90 had pleurisy. In the age group 20 years or less there were 161 cases (295 per thousand); 21-30 years, 314 (139 per thousand); 31-40 years, 125 (92 per thousand); 41-50 years, 34 (63 per thousand), and 50 years or more, 23 (84 per thousand). The greatest incidence of cases was in the age groups 20 years or less and 21-30 years, which showed morbidity rates of 295 and 139 per thousand, respectively, a much higher figure than the general rate of 131 per thousand. There were 625 cases in white persons (136 per thousand), as against 30 in colored persons (176 per thousand). Only two cases occurred in persons of Japanese descent (50 per thousand). Thus Brazilian Negroes have a pulmonary tuberculosis morbidity rate about 30 per cent higher than do white persons of similar social condition. The difference between the morbidity rates of Negroes and mulattoes was slight (187 and 167 per thousand, respectively), but the fate of the two groups of patients was dissimilar, as 12 of the 15 Negro patients died (80.0 per cent) while only two of the 15 mulatto patients died (13.3 per cent) during the same time of observation. The prognosis is much better in the case of white patients, as only 72 out of 625 died (11.5 per cent). These rates show a good correlation with the frequency of the different forms of the disease presented by these patients: in 15 Negro patients, 12 presented very advanced tuberculosis, while in 15 mulattoes only five and in 625 white persons only 75 showed a similar condition. Minimal lesions were present in only three Negro patients, while they occurred in nine mulattoes and in 494 white persons.

Early and Late Montenegro Reaction for Leishmaniasis.—Dr. A. Rotberg, assistant professor of clinical dermatology at São Paulo University, published a report on his experimental study on Montenegro's reaction for leishmaniasis, with the aim of comparing the results of the early and late reading of the reaction as well as the variation in reactivity with different concentrations of the antigen. The author studied the reaction, in 55 cases of American tegumentary leishmaniasis and in 29 controls, to the intradermal injection of 0.1 cc. of five suspensions of leptomonas of Leishmania braziliensis, in dilutions of 1:10,000,000 to 1:1,000 (organisms per cubic centimeter). He noticed that more than half of the controls showed, in 48 to 72 hours, small papules up to 5 mm., which in some cases remained for two or more weeks, thus causing doubt. In leishmaniasis, the 48 to 72 hour "early" reactions were distinctly more inflammatory, 6 mm. or larger in 92.7 per cent with the 1:10,000,000 dilution and in 72.7 per cent with the 1:1,000 dilution. Vesicular, pustular and bullous reactions were seen in some cases. In the early reactions an inflammatory peripheral halo was observed in 69.1 per cent and 27.3 per cent, respectively. The author suggests the 1:10,000,000 dilution as standard for Montenegro's reaction, as it is sufficiently sensitive without loss of specificity.

As the halo fades away, a central elevation becomes more apparent and dusky colored about the fifth to the eighth day and remains so for one or two weeks or more, before involution. Necrosis or ulceration in these "late" reactions occurs in 25.4 and 14.5 per cent of the cases with the 1:10,000,000 and the 1:1,000 dilutions, respectively. The author suggests that the reading of Montenegro's reaction be made both at 48 hours and 15 days after the injection. He believes that the late reaction is not just a persistence or a residue of the early phase but rather a distinct although concurrent feature, considering the following facts: 1. The area occupied by the early reaction, especially including the halo, is wider than that of the late one, which, in addition, is at its peak when the early reaction is fading or gone. 2. There is no direct correlation between the intensity of both phases, as there are many reactions with halo not followed by necrosis, as well as necrotic reactions not preceded by halo. 3. In 13 out of 55 cases the author observed that with the weaker concentrations of leptomonas (10,000 and 1,000) very slight or negative early reactions could be obtained, which, notwithstanding, changed, about the fifth to the eighth day, into small (3-4 mm.) but typical infiltrations of the late type.

Complement Fixation Test with Rickettsial Antigens.—The use of the complement fixation test as an indication of Rickettsia rickettsi infection in dogs was tried by Drs. H. G. Pereira and J. Travassos, of the Oswaldo Cruz Institute, as previously done by Shepard and Topping. With the serums of dogs from both spotted fever areas and Rio de Janeiro, where the occurrence of this disease is remote, frequent positive results were obtained. The test was studied in more detail by the use of Plotz type antigens purified by repeated washing. These antigens were prepared by method 2 of Shepard and Topping from normal and infected yolk sac suspensions. Rickettsiae of Rocky Mountain spotted fever, South African tick bite fever and Q fever were used. With the soluble (filtered supernatant) and nonsoluble (washed rickettsial suspension) antigens, the serums of Rio de Janeiro dogs gave negative results with the latter, whereas the same serums reacted, sometimes markedly, with the soluble antigens both of rickettsial and normal yolk sacs. A certain relation was found between the degree of complement fixation and the nitrogen content of the antigen used.

The relatively slight growth of rickettsiae of the Rocky Mountain spotted fever group in the yolk sac of chick embryos makes it difficult to obtain Bengtson type antigens with high titers, and these are often used in low dilutions or even undiluted. As these nonpurified antigens have a high protein content, it is understandable that they react in the presence of serums from dogs free from any rickettsial infection. These false positive reactions may be avoided by the use of antigens with high titer and even more by the use of specific antigens, that is, washed and concentrated rickettsial suspensions.

Positive Frei Reaction in Asymptomatic Lymphogranulomatosis.—Applying the Frei reaction with Lygranum antigen in 110 prostitutes of the city of São Paula, Drs. Carlos S. Lacaz and Raphael Treiger found 36 positive results (32.7 per cent). The test was made in cases in which anamnestic data did not reveal any lymphogranulomatic infection. These results disclose the exitsence of asymptomatic or nonrelated forms of venereal lymphogranulomatosis which may play a relevant part in the dissemination of this disease.

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CORRESPONDENCE

OSCAR EWING DESTROYS PAMPHLET

Federal Security Administrator Oscar Ewing announced to press association representatives on April 14 that publication has been stopped and existing stocks destroyed of an FSA publication, "Common Human Needs," containing language to which the American Medical Association objected. The FSA acted after repeated protests from Dr. Elmer L. Henderson, President of the American Medical Association. Dr. Henderson's original protest appeared on his "President's Page" in THE JOURNAL March 31, 1951.

REACTIONS TO DEXTROSE

To the Editor:—I was much interested in the correspondence of Drs. Feinberg, Huber, Black, Figley and Loveless in THE JOURNAL of March 3, 1951 (page 666). These letters were evoked by an editorial entitled "Reactions to Dextrose" in THE JOURNAL, Dec. 16, 1950, wherein attention is called to the claim by Theron Randolph and his co-workers that allergic reactions from intravenous injections of dextrose occur in corn-sensitive patients.

The editorial, which appears to support the validity of this claim, is epitomized by the following statement: "It is therefore not surprising that there should be occasional reactions to intravenous injections of dextrose that is prepared from simple hydrolysis of corn starch." This statement has been amply and adequately taken to task by the aforementioned group of allergists. I am in complete agreement with everything they stated.

I should, however, like to add some observations in refutation of the following statement which appeared in the editorial: "These authors demonstrated that crystalline sugars prepared from corn starch may cause intensive allergic reactions when ingested by persons highly sensitive to corn." Our observations are gleaned from experimental work done in the guinea pig (Ratner, B., and Gruehl, H. L.: Anaphylactogenic Properties of Malted Sugars and Corn Syrup, *Am. J. Dis. Child.* **49:**307 [Feb.] 1935), which I believe may cast some doubt on the statement that dextrose does possess allergenic properties.

Corn syrup is manufactured as follows: Corn starch is suspended in water and heated in an autoclave by steam in the presence of a small amount of a catalyst (pure hydrochloric acid). Hydrolysis ensues, and the resulting solution is free from starch when removed from the converter. The carbohydrates are present as reducing sugars, dextrose and some maltose and dextrin. At the end of the conversion the acid solution is neutralized to the proper pH value. The precipitate formed at this point is removed by mechanical filtration. A series of filtrations through animal charcoal follows for purification and decolorization. The concentration is stopped at the proper specific gravity for this syrup.

Our experimental results with corn syrup showed that, in 19 guinea pigs given intraperitoneal injections with corn syrup and challenged intravenously three or four weeks later with a 10 per cent solution of corn syrup, in not a single animal was any allergic reaction manifested. Of three animals receiving injections of a standard brand of corn syrup and challenged later by a shock injection of dextrimaltose, all gave a negative reaction. Of 10 animals given injections of dextrimaltose and challenged later by an intravenous shock injection of standard corn syrup, all gave a negative reaction.

We concluded from these experiments that corn syrup is nonanaphylactogenic. We believe that corn syrup is nonanaphylactogenic because the corn starch is heated in an autoclave in the presence of pure hydrochloric acid, which results in complete hydrolysis. The precipitate formed is removed by mechanical filtration.

Although corn syrup contains 0.2 per cent of protein, the soluble proteins of corn starch become insoluble in the process of cooking. Despite the 0.2 per cent protein (based on the standard protein factor N $\times$ 6.25) which is present in corn syrup, the absence of immunologic reactions to it may be due to the fact that the nitrogen which remains after the proteins have been coagulated and removed by filtration probably represent nonprotein nitrogen or denatured protein. These experimental findings indicate that it is unlikely that corn syrup or other crystalline sugars play a role in the phenomena described by Randolph and co-workers and attributed to allergy.

It is interesting to note that, when less purified sugars were used, such as Barley malt and malt extracts, the following results were obtained: Of 59 animals used in our study of Barley malt and malt extracts, 45 animals manifested varying degrees of anaphylactic shock, 28 died in anaphylactic shock and 17 showed symptoms of shock with recovery. From these figures we concluded that these mother substances are highly anaphylactogenic.

With further purification of malt extracts we obtained the following results: Of 79 animals used in our study of reactions to the combination of dextrins and maltoses, all gave negative reactions, showing that sugars derived from malt, potato and corn were all nonanaphylactogenic. The original substances appeared, therefore, to lose their antigenic properties in the process of hydrolysis. These negative allergic responses were obtained with 5, 10 and 20 per cent solutions given intravenously.

When extraneous substances such as wheat germ or dried milk were added to the nonanaphylactogenic dextrimaltose, the antigenic properties resident in these manufactured products were shown to be due to the added protein.

We believe that our experiments make it apparent that pure dextrins and maltoses or corn syrup do not play the role in allergy ascribed to them by Randolph and his co-workers. Therefore, if allergy to crystalline sugar preparations occurs at all, it must be attributed to protein constituents that are added to certain of these carbohydrate substances.

It is argued that human beings differ in this respect from guinea pigs; however, this may not be correct, for what we are testing is antigenicity and not species susceptibility.

It is universally conceded that an antigen proved to be anaphylactogenic in the lower animal is by the same token allergenic to the human species. We believe Randolph and his co-workers have not proved their claims, for no real experimental data is offered except clinical observations, which may be subject to other interpretation.

BRET RATNER, M.D.,
50 East 78th Street, New York 21.

MYASTHENIA GRAVIS AND ADRENOCORTICAL INSUFFICIENCY

To the Editor:—I should like to comment on your abstract of the very interesting article by Drs. Kane and Weed on the "unique association" of myasthenia gravis and adrenocortical insufficiency, published in the *New England Journal of Medicine* (**243:**939 [Dec. 14] 1950) and abstracted in THE JOURNAL, (**145:**932 [March 24] 1951).

Far from being unique, the association of these two conditions may be the rule. Brem and Wechsler (*Arch. Int. Med.* **54:**901 [Dec.] 1934) submitted a theory to explain the occurrence of thymomas in this disease, namely, that the pathological changes in the thymus are secondary to degenerative lesions of the suprarenal. Also suggestive of the relation of the adrenals to pathology in the thymus is the finding of Sloan (*Surgery* **13:**154 [Jan.] 1943) that the thymus glands of three of seven patients with Addison's disease showed changes like those in myasthenia gravis.

In a patient of Barton and Branch (*J. A. M. A.* **109:**2044 [Dec. 18] 1937) adrenal involvement was found on microscopic examination; there were small areas of focal necrosis in the cortex, which was invaded by neutrophils. Adrenal pathology was also noted in the only recorded instance of a newborn infant with myasthenia gravis by Stickroot and co-workers (*J. A. M. A.* **120:**1207 [Dec. 12] 1942).

EDWARD E. BROWN, M.D.,
25 North Main,
Ashland, Ore.

MEDICAL LITERATURE ABSTRACTS

AMERICAN

A.M.A. Arch. Internal Medicine, Chicago

87:181-328 (Feb.) 1951

*Penicillin Treatment of Infectious Mononucleosis: Comparison of Effects in 99 Patients With and in 67 Patients Without Penicillin Therapy. T. Bennike.—p. 181.
Combined Administration of Desoxycorticosterone Acetate and Ascorbic Acid: I. Clinical Results in Rheumatoid Arthritis and Laboratory Studies. J. B. R. McKendry, C. A. Schaffenburg and E. P. McCullagh. —p. 190.
Id.: II. Experimental Observations. C. A. Schaffenburg, J. B. R. McKendry and E. P. McCullagh.—p. 199.
*Q Fever in California: III. Aureomycin in Therapy of Q Fever. W. H. Clark, E. H. Lennette and G. Meiklejohn.—p. 204.
The Eisenmenger Complex and Its Relation to Uncomplicated Defect of Ventricular Septum: Review of 35 Autopsied Cases of Eisenmenger's Complex, Including Two New Cases. A. Selzer and G. L. Laqueur. —p. 218.
Observations on Case of Idiopathic Hypoparathyroidism. A. Jordan and A. R. Kelsall.—p. 242.
Allergic Granuloma of Lung: Clinical and Anatomic Findings in Patient with Bronchial Asthma and Eosinophilia. J. C. Ehrlich and A. Romanoff.—p. 259.
Chronic Regurgitation Jaundice as Presenting Sign in Sarcoidosis. P. H. Ross and B. J. Weinberg.—p. 269.
Syncope in Aortic Stenosis. J. F. Hammersten.—p. 274.

Penicillin in Infectious Mononucleosis.—In a total of 835 patients admitted to a Copenhagen Hospital with symptoms of acute tonsillitis, 166 were found to have infectious mononucleosis. This diagnosis was based on the usual clinical and hematological criteria. The Paul-Bunnell agglutination test was performed on 153 patients, this being supplemented by the absorption test of Davidsohn in all patients with titers above or equal to 1:32. The erythrocyte sedimentation rate, the Wassermann reaction and the antistreptolysin titer were determined, and electrocardiograms were made twice during the stay in the hospital. Swabs for hemolytic streptococci were taken daily from all patients for at least six days. All tests were repeated at the follow-up examination one month later. The patients were admitted to a "penicillin ward" and a "control ward," each of which received patients on alternate days, though patients who had received penicillin treatment before admission were chiefly placed in the "penicillin ward." A total of 99 received penicillin treatment. Adults received 150,000 units of soluble sodium salt of penicillin intramuscularly twice daily for six days, and children received smaller doses. The patients in the control group were treated symptomatically. Throat culture revealed beta hemolytic streptococci group A in 25 per cent of the patients. Penicillin treatment had no effect on the duration of fever, presence of exudate or persistence of sore throat, and the average stay in hospital was the same in both groups (13.4 days). Pyogenic complications (otitis media, phlegmonous tonsillitis) occurred in a few of the control patients. Slight electrocardiographic changes occurred with equal frequency in the two groups. The author concludes that penicillin has no effect on the clinical course of mononucleosis as such, but it inhibits the streptococci and thus presumably prevents complications.

Aureomycin in Q Fever.—Of the 45 patients with Q fever who were treated with aureomycin, 25 were treated by the oral route alone, 10 by the oral and intravenous routes combined, seven by the oral and intramuscular routes combined, two by the intramuscular route alone and one by the intravenous route alone. The oral dose ranged from 1 to 5 Gm. daily in divided doses given at four to eight hour intervals. The intravenous dosage was either 200 or 300 mg. per 24 hours. The intramuscular dosage ranged from 40 to 400 mg. per 24 hours. When aureomycin became available for intravenous use, this route supplanted the intramuscular. The results obtained with aureomycin are compared with those obtained in 25 Q fever patients, all but one of whom were treated with a repository type of penicillin. Thirty-two of 45 patients treated with aureomycin became afebrile in five days or less. Of the patients treated with penicillin, only seven of 25 became afebrile in the same period. Nine of the aureomycin-treated patients, who did not become afebrile in five days or less nevertheless showed subjective improvement and a decided drop in temperature. No such effects were noted among the patients treated with penicillin. The third group of four patients showed either minimal or no improvement in response to aureomycin therapy. There is no explanation for this failure. The authors conclude that aureomycin is useful in the treatment of Q fever.

A.M.A. Arch. Neurology and Psychiatry, Chicago

65:131-264 (Feb.) 1951

Postherpetic Trigeminal Neuralgia. O. Sugar and P. C. Bucy.—p. 131.
*Tuberculomas of Brain: Report of 159 Cases. A. Asenjo, H. Valladares and J. Fierro.—p. 146.
*Encephalitic Form of Metastatic Carcinoma. L. Madow and B. J. Alpers. —p. 161.
Effects of Decamethonium Bromide (C 10) and d-Tubocurarine on Electroconvulsions. L. H. Margolis, A. Simon and K. M. Bowman.—p. 174.
Clinical and Physiological Studies in Case of Myokymia. H. Holland de Jong, I. A. Matzner and A. A. Unger.—p. 181.
Retrobulbar Neuritis Associated with Hyperthyroidism. M. A. Goldzieher, T. H. McGavack, C. A. Peterson and others.—p. 189.
Effect of Prefrontal Lobotomy on Temperature Regulation in Schizophrenic Patients. C. W. Buck, H. B. Carscallen and G. E. Hobbs. —p. 197.
Clinical and Psychological Investigation of Prefrontal Lobotomy in Chronic Schizophrenia. H. B. Carscallen, C. W. Buck and G. E. Hobbs. —p. 206.

Tuberculomas of Brain.—In the course of about 10 years 159 cases of tuberculoma of the central nervous system were observed at the Neurosurgical Institute in Santiago, Chile; 97 were histologically verified. The ages of these patients ranged from 19 months to 70 years. Family contact with tuberculosis was definitely proved in 44 of these cases, and in 11 others it was strongly suspected. Extraneural tuberculosis was demonstrated in 86 cases, but pulmonary tuberculous lesions are evidently not always present, because among the 49 cases who came to necropsy there were six who had no pulmonary signs. Roentgenologic examination also failed to reveal a pulmonary process in some of the cases. Increased intracranial pressure, the most important symptom, was severest in the patients in whom the tuberculoma was in the posterior fossa and in those in whom multiple tuberculomas existed. A total of 53 of the 97 patients had multiple tuberculomas. The growths attached to the meninges were more benign than the tuberculomas located in the substance of the brain. Granular ependymitis and granular choroiditis present in some cases showed no evidence of tuberculosis, but in other cases microscopic tuberculomas were found within these granulations. Besides the headache resulting from intracranial hypertension, the presence of papilledema and neurological disturbances are important in the diagnosis. Encephalographic and ventriculographic studies were made in 84 of the 97 patients. These methods and arteriography and electroencephalography are important for the localization of the tuberculoma. Before streptomycin became available, surgical treatment was usually limited to decompression; there was only one survival in the six cases in which removal of the growth was attempted. Of the 10 patients who were given streptomycin in connection with the surgical treatment, only two died. In one of these two, operation was limited to opening of the lamina terminalis, because of the presence of a large hydrocephalus and a poor general condition. The other patient was found to have multiple tuberculoma, and no definite treatment was attempted.

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Titles marked with an asterisk (*) are abstracted.

Four patients had complete recovery with radical operation; two, with decompression, and two, with opening of the lamina terminalis.

Encephalitic Form of Metastatic Carcinoma.—Extension of carcinomatous lesions to the nervous system may become manifest in the form of a solitary metastasis to the brain or of multiple metastases of varying number and size. Less common, and not sufficiently recognized for either its pathological or its clinical features, is the encephalitic form of carcinomatous metastasis, which may closely simulate encephalitis of other types. The histories of four patients who had this carcinomatous form of encephalitis are described in this paper. Clinically, the cases varied significantly, but all four patients had signs of meningeal irritation, all had convulsions, three of the four had mental changes and three of the four had hemipareses. In all cases there was infiltration of the brain and meninges, with carcinoma cells strewn throughout the substance of the brain, collected in tiny discrete nodules or located in the perivascular spaces. In three of the four cases the primary source was in the lung; in the fourth the primary site was not determined. The incidence of this condition among all metastatic carcinomas seen by the authors was 3.8 per cent. It should always be suspected in middle aged or older patients with what appears to be an encephalitic process of undetermined origin.

A.M.A. Arch. Surgery, Chicago

62:151-302 (Feb.) 1951

Gastric Resection in Treatment of Peptic Ulcer. F. Glenn and C. S. Harrison.—p. 151.
Vagotomy in Treatment of Duodenal Ulcer: Results in 350 Consecutive Cases. J. Weinberg, A. R. Kraus, S. J. Stempien and F. B. Wilkins.—p. 161.
*Combined Procedure of Partial Gastrectomy and Infradiaphragmatic Vagus Resection. L. T. Palumbo, F. M. Marquis and A. N. Smith.—p. 171.
*Physiological and Clinical Studies of Vagotomized Patients: Study of 331 Patients. W. Walters, H. H. Belding III and W. I. Lillie.—p. 183.
Principles, Problems, Practices of Anesthesia for Thoracic Surgery. H. K. Beecher.—p. 206.
Aureomycin Therapy in Lymphogranuloma Venereum. A. Fletcher, M. M. Sigel and H. A. Zintel.—p. 239.
Anesthesia for Infants and Children: Nonbreathing Technic. H. M. Slater and C. R. Stephen.—p. 251.
Amebic Abscess of Liver—Therapeutic Approaches. R. M. Miles and R. F. Bowers.—p. 260.
Congenital Dilatation of Common Bile Duct: Report of Two Cases in Children. J. H. Hertzler and C. E. Maguire.—p. 275.

Partial Gastrectomy and Vagotomy.—Palumbo and associates studied the effect of adding bilateral infradiaphragmatic vagus resection to their routine procedure of partial gastrectomy for peptic ulcer. Twenty-five consecutive patients with duodenal ulcer were subjected to the combined procedure and were followed for 28 to 41 months. Seventeen of the patients obtained symptomatic relief. In all patients, delayed emptying time of the stomach could be demonstrated postoperatively and there was complete and persistent absence of free hydrochloric acid. The authors feel that these two factors should reduce the incidence of marginal or jejunal ulcers, eliminate one of the causes of the dumping syndrome and possibly permit the performance of a less radical gastric resection, although a longer observation period will be necessary to establish these facts. The majority of disabling symptoms seen after vagotomy alone were not present in these patients. The addition of vagotomy to partial gastric resection did not increase the operative mortality but did increase the immediate postoperative morbidity. Dysphagia developed in one patient as a result of trauma to the esophagus during mobilization of the vagus nerve, and in a second patient hemorrhagic pericarditis appeared, possibly due to similar operative trauma.

Indications for Vagotomy.—A study of the physiological and clinical results of vagotomy performed alone and in combination with gastroenterostomy, pyloroplasty and gastric resection was made in 331 patients operated on at the Mayo Clinic. These results were compared with those obtained in 2,558 cases collected by the Vagotomy Committee of the American Gastroenterological Association. The authors reached the following conclusions: 1. There is little place for vagotomy alone in the treatment of duodenal ulcer. 2. Vagotomy may be combined with gastroenterostomy in highly nervous middle aged men who have duodenal ulcers that are too large for safe removal and that would interfere with safe closure of the duodenal stump if gastric resection were carried out. Vagotomy may be combined with pyloroplasty or gastroduodenostomy when the duodenal ulcer is small, and with gastric resection in selected persons of the high tension type who have large amounts of free hydrochloric acid. 3. Vagotomy is indicated after adequate gastric resection if gastrojejunal ulceration occurs. It may be combined with further gastric resection when gastrojejunal ulcer is found after inadequate gastric resection. 4. When a small gastrojejunal ulcer or gastrojejunitis occurs after gastroenterostomy, vagotomy should be used only in poor risk patients, since one can obtain better results by undoing the gastroenteric anastomosis and performing partial gastrectomy. Disconnection of the anastomosis and reestablishment of gastroduodenal continuity combined with vagotomy are followed by a high incidence of reactivation of duodenal ulcer. 5. Vagotomy should not be performed for gastric ulceration because of the high incidence of unsuspected malignant processes and because the postoperative results compare unfavorably with the excellent results obtained from gastric resection.

American Journal of Medicine, New York

10:1-130 (Jan.) 1951

Clinical Variations in Primary Atypical Pneumonia. W. S. Jordan Jr., R. W. Albright, F. H. McCain and J. H. Dingle.—p. 3.
Dynamics of Isolated Pulmonary Stenosis. E. N. Silber, O. Prec, N. Grossman and L. N. Katz.—p. 21.
Chronic Cor Pulmonale in Long-Standing Bronchial Asthma. M. L. Gelfand.—p. 27.
Syphilitic Cardiovascular Disease Combined with Chronic Endocardial Lesions Usually Attributed to Rheumatic Fever. J. R. Smith, J. A. Saxton Jr. and H. C. Fritz.—p. 37.
Rheumatic Fever and Glomerulonephritis. Clinical and Postmortem Study. S. A. Hartman and E. F. Bland.—p. 47.
Blood Levels of Urea Nitrogen, Phenol, Guanidine and Creatinine in Uremia. N. S. Olsen and J. W. Bassett.—p. 52.
Experimental Studies of Irritable Colon. T. P. Almy.—p. 60.
*Use and Abuse of Thiouracil Drugs. G. O. Bell and G. I. Mishtowt.—p. 68.

Use and Abuse of Thiouracil Drugs.—After describing a case that exemplifies the misuse of propylthiouracil in patients with hyperthyroidism, Bell and Mishtowt appraise the current status of the thiouracil derivatives in the treatment of hyperthyroidism on the basis of the records of 56 patients referred to the Lahey Clinic for surgical treatment. Examples of the misuse of these drugs were found in these cases. The commonest errors are failure to control the hyperthyroidism completely, usually as the result of inadequate dosage; treatment of diseases not suited for prolonged medical treatment, such as intrathoracic goiters, very large adenomatous goiters or large exophthalmic goiters; mistaken diagnosis—chiefly the use of prolonged antithyroid treatment in patients with anxiety neurosis, and the use of such small dosages that little is accomplished beyond exposure of the patient to the possibility of drug sensitivity. With regard to prolonged thiouracil therapy in hyperthyroidism, the authors stress that full control of the hyperthyroidism throughout medical treatment is an absolute necessity. Remission cannot be expected if low grade hyperthyroidism is allowed to persist during treatment. In general, it would be better to err on the side of overtreatment. Toxic reactions to propylthiouracil occur in 2 per cent of patients, and in 0.6 per cent of patients agranulocytosis develops. Prolonged treatment should not be undertaken unless the patient will be under supervision. The type of hyperthyroidism most likely to respond to medical treatment is primary hyperthyroidism or Graves' disease, with small glands and mild toxicity. Patients with adenomatous goiters are probably not suitable for medical treatment. For recurrent primary hyperthyroidism following operation, some authors recommend only medical treatment, whereas others recommend surgical treatment. The consensus is that treatment must be prolonged if remissions are to be permanent. Length of treatment varied from three months to two years, but some patients relapsed after cessation of therapy, although treatment had lasted two years.

American J. Obstetrics and Gynecology, St. Louis

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Cancer of Cervix. Realistic Program of Cancer Control for General Practitioner. L. B. Greentree.—p. 178.

Routine Antenatal Chest X-Ray Findings.—Analysis is made of the observations on routine chest photofluorography in 3,576 pregnant women. Four per cent of all patients gave evidence on the microfilm of chest lesions warranting diagnostic study. Half of these proved insignificant or could not be adequately studied. The remainder comprised 0.8 per cent of the total group, in whom clinically important nontuberculous pathological conditions were diagnosed, principally cardiovascular disease, and in 1.2 per cent pulmonary tuberculosis was diagnosed. The single microfilm screening of all prenatal referrals resulted in the discovery of tuberculosis, not suspected by the obstetrician, in 14 women, or one in 255. The remaining cases of tuberculosis were either known previously or referred as suspicious. Postpartum roentgenograms taken from one to 20 months after delivery revealed 10 cases of pulmonary tuberculosis not previously suspected. Five of these patients had been reported as normal on the screening examination. Thus among 42 women with tuberculosis in pregnancy or the puerperium the routine screening mechanism failed to yield a warning in one out of eight. The advisability of securing a second microfilm in all cases, near term or during the lying-in period or at the time of the six to eight-week postpartum visit, is strongly suggested. Comparison of the group in whom diagnosis was made prenatally with those whose disease was discovered after delivery shows a marked difference in fatality, with a more disastrous course of the disease in both mothers and infants among the latter group. The authors' observations support the view that x-ray examination of the chest in all pregnancies is a highly useful procedure in terms of newly discovered tuberculous lesions otherwise unknown to the obstetrician. An additional value of the method is attested by the frequent disclosure of nontuberculous thoracic pathology of clinical importance.

Intratubal Term Pregnancy Without Rupture.—The occurrence of true intratubal full term pregnancy without rupture is reported in one primigravid woman aged 28 years; 44 additional cases from the literature were full term or nearly full term without rupture. The fetal mortality for the 45 cases was approximately 75 per cent and the maternal mortality about 10 per cent. The authors suggest the following criteria for the diagnosis of intratubal pregnany near or at term without rupture: (1) that complete extirpation of the fetal sac and products of conception be achieved by salpingectomy; (2) that there be no gross or microscopic evidence of tubal rupture; (3) that ciliated columnar epithelium be demonstrated at some few points in the inner lining of the sac, and (4) that smooth muscle be found in the sac wall at multiple sites and at some distance from normal, undilated tube. Not all the listed cases of pregnancy have met these rigid criteria, but in all the cases there was no gross evidence of tubal rupture and the fetus and membranes were or could have been completely extirpated by local adnexal surgery. In several of the reports the surgeons, during the early stages of the operation for this condition, believed themselves to be dealing with the uterus while they were actually handling the fallopian tube. This misconception was shared by the authors in their own case. In the reports and in the authors' case, there were unsuccessful attempts to induce labor, and there was absence of dilatation and of effacement of the cervix. Recovery of the authors' patient was uneventful.

American Journal of Pathology, Ann Arbor, Mich.

27:1-174 (Jan.-Feb.) 1951

Ocular Changes Produced by Total Body Irradiation. H. C. Wilder and R. M. Maynard.—p. 1.
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*Diastasis and Diastatic Perforation of Gastro-Intestinal Tract. Clinical, Pathologic and Experimental Study. J. M. Ravid.—p. 33.
Effect of Hepbisul (Heptyl Aldehyde-Sodium Bisulfite Addition Compound) and Thyroxin on Walker Rat Carcinoma 256. P. A. Herbut, W. H. Kraemer and J. Jacksen.—p. 59.
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Transmissible Venereal Tumor of Dog Studies Indicating That Tumor Cells Are Mature End Cells of Reticulo-Endothelial Origin. F. Bloom, G. H. Paff and C. R. Noback.—p. 119.
Acid Mucopolysaccharide in Degenerative Disease of Connective Tissue, with Special Reference to Serous Inflammation. C. H. Altshuler and D. M. Angevine.—p. 141.
Arteritis of Striated Muscle in Rheumatoid Arthritis. L. Sokoloff, S. L. Wilens and J. J. Bunim.—p. 157.

Diastasis of Gastrointestinal Tract.—The clinicopathological syndrome of diastasis of the gastrointestinal tract was studied in 81 cases, 71 collected from the literature and 10 from the author's clinical material. Diastatic perforation occurred in 78. In this syndrome a more or less normal segment of bowel undergoes considerable distention, as a result of an intrinsic or extrinsic obstructive lesion within a distally situated segment of the intestine. In the distended portion of the intestine, there is tearing of the serosal and mucosal coats and possible ultimate perforation. In five of the author's 10 cases the proximal segment was enormously distended, but remained intact. In the majority of cases (55) the diastatic process involved the right side of the colon, since the primary obstructive lesion was most frequently situated in the left side of the colon. Carcinoma was the most frequent cause, having occurred in 53 cases. Other primary stenosing lesions in the intestine were congenital atresia, chronic granuloma or extrinsic lesions in the form of adhesive bands, tumors or cysts. The ileocecal valve plays an important part in the diastatic process. When it is patent, no perforation of the colon will take place. When it is closed, a closed loop obstruction will be formed, and the distention, unless relieved in time, will lead to perforation. Rarely, when the obstruction is within the cecum itself, the distention may be transmitted to the ileum. In "spontaneous" perforation of the stomach and esophagus, the pyloric and cardiac sphincters play a part similar to that of the ileocecal valve. Diastasis and perforation are best explained on a mechanical basis, but toxic infectious and vascular factors may, at times, also contribute to the process. In distention experiments on the stomach and intestine, the sites and general character of the tears resembled very closely those observed clinically. Early recognition of the diastatic syndrome is essential for proper treatment of both the primary obstructive and the secondary diastatic disease.

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Am. J. Syphilis, Gonorrhea and Ven. Dis., St. Louis

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Immunochemical Studies of Reiter Spirochete. A. Gelperin.—p. 1.
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Auzias-Turenne's Syphilization Method in Norway: Unsuccessful Attempt at Biologic Syphilis Therapy in Middle of Last Century. S. W. Erichsen.—p. 42.
Third Generation Syphilis. G. C. Sauer.—p. 53.
Treatment of Secondary Syphilis with Procaine Penicillin and Aluminum Monostearate—Progress Report in Evaluation of Therapy. W. H. Aufranc and E. V. Price.—p. 57.
*Treatment of Early Syphilis with Four Weekly Injections of Procaine Penicillin and Aluminum Monostearate: Preliminary Report. W. C. Buschemeyer, A. B. Loveman and F. B. Zaugg.—p. 67.
Penicillin Therapy of Nontabetic Spinal Cord Syphilis. R. W. Jones Jr., A. Heyman, W. A. Smith and R. Wilson.—p. 72.
Nongonococcal Neisserian Strains Isolated from Genitourinary Tract. J. Johnston.—p. 79.
Use of Oral Penicillin in Buffered Sulfonamide Mixture in Treatment of Acute Gonorrheal Urethritis. P. B. Johnson, J. H. Seabury and D. M. Dumville.—p. 83.

Early Syphilis Treated with Four Weekly Injections.—Buschemeyer and associates call attention to the delayed absorption of small-sized procaine penicillin particles suspended in peanut oil jelled with 2 per cent aluminum monostearate. A single injection of 300,000 units of penicillin, suspended in 1.0 cc. of this vehicle, produced and maintained a serum concentration greater than the theoretical therapeutic minimum for over four days in most cases studied. Since there is a definite recovery period before surviving organisms again begin to multiply, it seemed that a brief lapse in adequate blood serum levels was not only permissible but possibly helpful in making the surviving organisms more vulnerable, as was suggested by Bigger. The authors gave a weekly injection of 300,000 units of procaine penicillin in oil and aluminum monostearate for four consecutive weeks. A weekly physical inspection and serologic test for syphilis were done on each patient. Following the treatment, a monthly physical examination and serologic tests for syphilis were done for the first year and at three month intervals thereafter. An examination of the cerebrospinal fluid was made between the sixth and twelfth post-treatment months or earlier in any case showing evidence of a possible serologic relapse. A total of 102 cases of primary and secondary syphilis were treated, and more than 85 per cent have been followed for more than six months. Clinical cures to date represent 94.7 per cent of the cases followed, with 5.3 per cent showing evidence of clinical relapse. The over-all satisfactory results (clinical and serologic) were 89.3 per cent, which decreases to 87.2 per cent if the two cases of possible reinfection are counted as unsatisfactory.

Am. Practitioner & Digest of Treatment, Philadelphia

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Parathion Poisoning. D. O. Hamblin and J. F. Marchand.—p. 1.
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Kidney Tumors: Types, Diagnosis, Treatment. H. M. Spence, S. S. Baird and F. Fuqua.—p. 22
Value of Red Cell Survival Studies. B. Fisher.—p. 29.
Controlled Study of Treatment of Upper Respiratory Infection with Prophenpyridamine (Trimeton). H. L. Hirsh.—p. 32.
Muscular Dysfunction Under Emotional Stress: Diagnosis and Treatment. A. D. Jonas.—p. 36.
Acute Renal Failure. J. G. Weiner.—p. 45.
Oral Estrogen Therapy in Menopause Syndrome: Some Comparison of Products of Synthetic and Natural Origin. H. W. Coone and R. F. Escamilla.—p. 51.
Pneumonia Associated with Chickenpox: Report of Patient Treated with Aureomycin. J. C. Michel, D. H. Coleman and W. M. M. Kirby.—p. 57.
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Radiation Therapy as Adjunct to Surgery in Cancer of Breast. B. F. Byrd Jr.—p. 65.
Clinic H: Haven for Hypochondriacs. H. Hunter and J. M. Lyon.—p. 67.
Clinical Aspects of Gynecologic Endocrinology. E. Matlin.—p. 70.

Annals of Internal Medicine, Lancaster, Pa.

34:1-310 (Jan.) 1951

*Treatment of Typhoid Fever: I. Combined Therapy with Cortisone and Chloramphenicol. J. E. Smadel, H. L. Ley Jr. and F. H. Diercks.—p. 1.
Id.: II. Control of Clinical Manifestations with Cortisone. T. E. Woodward, H. E. Hall, R. Dias-Rivera and others.—p. 10.
Epididymitis in Mumps, Including Orchitis: Further Clinical Studies and Comments. S. Candel.—p. 20.
*Observations on Portal Cirrhosis with Ascites. W. E. Ricketts.—p. 37.
Effect of Some Steroids (Testosterone Propionate, Desoxycorticosterone Acetate and Ascorbic Acid, and 21-Acetoxy Delta-5-Pregnenolone, Aufrisone Acetate, Wyeth) in Rheumatoid Arthritis. H. M. Margolis and P. S. Caplan.—p. 61.
Obesity in Diabetes: Study of Therapy with Anorexigenic Drugs. K. E. Osserman and H. Dolger.—p. 72.
Electrocardiographic Patterns in Stokes-Adams Syndrome. B. H. Pastor and S. H. Worrilow.—p. 80.
Isolated Disease of Pulmonary Valve and Artery. A. L. Hyman, L. Levy II, R. Bagnetto and others.—p. 90.
Initial Attack of Acute Myocardial Infarction. T. P. Jacobs.—p. 114.
Atypical Pneumonia Treated with Streptomycin: Preliminary Report on Effectiveness of Streptomycin in Atypical Pneumonia. F. P. King.—p. 141.
Source of Error in Determination of Basal Metabolic Rates by Closed-Circuit Technic. H. N. Willard and G. A. Wolf Jr.—p. 148.
Metabolic Craniopathy: Review of Literature with Report of Case with Diabetes Insipidus. S. Dann.—p. 163.
*Respiratory Failure in Poliomyelitis: Simple Method for Its Recognition and Control. W. F. Stafford Jr. and R. Gurney.—p. 203.
Notes on Symposium: The Internist as a Psychiatrist. S. Wolf and H. G. Wolff.—p. 212.

Combined Treatment of Typhoid with Cortisone and Chloramphenicol.—Eight patients with typhoid were treated with chloramphenicol (chloromycetin®) and cortisone. An initial oral dose of 3 Gm. of chloramphenicol was given to the adult patients. It was followed by 1.5 Gm. at 12-hour intervals for five days, then 1.5 Gm. once daily for the next 10 or 11 days. One child aged 11 and one adolescent aged 15 received proportionate amounts of the drug equivalent to the adult dose on the basis of body weight. Cortisone was administered according to one of two schedules. The first group of patients received 200 mg. during the first 24 hours, followed by 100 mg. on each of the three succeeding days. The second group was given 300 mg. the first day, 200 mg. the second and 100 mg. on each of the two succeeding days. Cortisone was administered intramuscularly at intervals of six to 12 hours. Earlier experience with the use of chloramphenicol alone in the treatment of 44 patients with typhoid demonstrated that an average of four days was required before fever and toxemia disappeared. The typhoid patients who received the smaller doses of cortisone in addition to chloramphenicol had an average febrile period of 50.2 hours. Those receiving the larger doses of cortisone along with chloramphenicol were febrile for an average of 15.5 hours. The occurrence of two relapses of typhoid in the group of eight patients provided a higher incidence than would ordinarily be expected in patients who received a full two week course of chloramphenicol. Whether this was mere coincidence or was related to the supplementary use of cortisone cannot be stated at this time. The authors prefer to consider the beneficial effect of cortisone in the typhoid patient as resulting from action on the human host rather than directly on the typhoid organism or its products. The combined therapy appears to be of sufficient theoretical and practical interest to warrant further study.

Portal Cirrhosis with Ascites.—Fifty patients with untreated portal cirrhosis without cardiorenal disease were studied for analysis of the changes in the plasma proteins in cases of this type. Twenty healthy persons served as controls. Plasma albumin levels in patients with cirrhosis and ascites were consistently below 3 Gm. per 100 cc., while those of normal persons and patients with cirrhosis but without ascites exceeded this figure. The values for globulin did not exceed 2.8 Gm. per 100 cc. in the 20 normal persons, whereas higher values were frequently obtained in patients with portal cirrhosis. The rise in globulin on the average was higher in patients with ascites than in those

without ascites. Medical management of patients with or without ascites is similar except for sodium restriction in patients with ascites. Dietary management with a high protein, high carbohydrate and high caloric intake, plus additional choline chloride, was observed to improve nutrition and hepatic parenchymal regeneration, to bring about sustained rise in plasma albumin and thus to eliminate edema and ascites. This effect was obtained after continuous treatment for several months. Plasma albumin values apparently were restored only after repletion of tissue protein. Repeated paracenteses should be avoided, since they result in a pronounced loss of protein. No tendency to recurrence of ascites was seen in uncomplicated cases in which there was adequate nutrition. Results of medical management in 28 patients with portal cirrhosis, 14 with jaundice and severe hepatic failure and 14 with depletion of protein without symptoms of liver failure or jaundice, were as follows: In the first group, six of the 14 patients died in hepatic failure and coma. Of the eight surviving patients, ascites completely disappeared in seven and the eighth was greatly improved. Two of the seven patients died later of bleeding from esophageal varices. In the second group, ascites disappeared in 10. Three of the 10 subsequently died from esophageal varices without recurrence of ascites or edema. The immediate prognosis of jaundiced patients with ascites depends on the severity of the parenchymal failure. The ultimate prognosis of patients who have recovered from edema and ascites remains uncertain and is determined to a great extent by the incidence of complications, the most frequent of which is bleeding from varicose veins of the esophagus.

Respiratory Failure in Poliomyelitis.—Recognition of impending respiratory failure may be readily accomplished by the use of any basal metabolism apparatus capable of measuring vital capacity. Four stages in the development of respiratory failure are suggested as follows: reduction of tidal volume and vital capacity to approximately 350 and 1,000 cc. respectively; presence of periodic deep breaths and waxing and waning of the tidal volume; disappearance of the periodic deep breaths, and disappearance of the waxing and waning of the tidal volume, which is further reduced to approximately 200 cc. These aspects of respiratory function were used as criteria for the recognition of the incipient and advanced respiratory failure in five adult patients with poliomyelitis with respiratory involvement. Tracings were made during the early stages of respiratory failure, after total respiratory failure had ensued and the patients were in respirators and during the recovery period. With repeated respirograms taken during these various phases, it was possible to (1) anticipate respiratory failure before it was clinically evident, (2) determine and thus control the adequacy of ventilation produced by the respirator, (3) recognize certain pulmonary complications during artificial respiration before any recognizable clinical signs were present and (4) record graphically the return of respiratory function as well as to ascertain how long the patient could be removed from the respirator without fatigue. The necessity for measuring tidal and minute volumes during artificial respiration is emphasized.

Arizona Medicine, Phoenix

8:1-88 (Jan.) 1951

Diagnosis of Poliomyelitis. W. G. Campbell.—p. 25.
*Diethylstilbestrol (DES) in Treatment of Threatened Abortion. K. J. Karnaky.—p. 36.
Regurgitation Esophagitis. C. A. Janda and A. C. Van Ravenswaay.—p. 40.

Diethylstilbestrol in Threatened Abortion.—In earlier studies Karnaky demonstrated that contrary to previous fears concerning the effects of estrogen therapy during pregnancy, the tolerance for diethylstilbestrol in the pregnant woman is at least 1,000 times that of the nonpregnant woman. He presents observations on unselected patients with threatened abortion whom he treated with varying amounts of diethylstilbestrol. In the mild cases, with spotting and mild cramping for four to 12 hours, 100 mg. are given orally every 15 minutes until cramps, pain and spotting stop. Then 25 mg. three times a day are given for one week. A dose of 25 mg. is then given each morning up to the eighth month of pregnancy. If pain cramps and bleeding recur, doses of 100 mg. are administered every 15 minutes until these symptoms are dispelled; next, 25 mg. three times a day and once at night are given for two weeks, then 50 mg. every morning for two weeks and then 25 mg. every morning thereafter until the eighth month. In moderately severe cases (cramps and bleeding for about a day) and in severe cases (the same symptoms persisting for from two to four days) diethylstilbestrol is given not only in larger doses by mouth, but also intramuscularly. The author administered diethylstilbestrol to 125 patients with threatened abortion over the past nine years. Attention was given also to diet and particularly to vitamins. None of the patients were given bed rest, and the author believes that when diethylstilbestrol is given, bed rest can be dispensed with except in a few cases. In the 21 patients whose histories are briefly reported, the fetal salvage rate was 76 per cent. Massive doses of diethylstilbestrol cause no damage to mother or child.

Arkansas Medical Society Journal, Fort Smith

47:131-152 (Jan.) 1951

Conservatism in Gynecology. E. C. Hamblen.—p. 131.
Medical Planning for Atomic Disaster. W. L. Wilson.—p. 136.

47:153-168 (Feb.) 1951

Acute Obstruction of Small Intestine. F. G. Kumpuris.—p. 153.
Cancer of Colon and Rectum. S. W. Hawkins.—p. 157.

Bulletin New York Academy of Medicine, New York

27:63-126 (Feb.) 1951

Rheumatoid Arthritis: Natural History of the Disease and Its Management. C. Ragan.—p. 63.
Clinical Effects of Cortisone and ACTH on Rheumatic Diseases. J. J. Bunim.—p. 75.
Pyogenic Arthritis. A. Steindler.—p. 101.

Circulation, New York

3:1-160 (Jan.) 1951

*Controlled Observations on Effect of Low Sodium Dietotherapy in Essential Hypertension. A. C. Corcoran, R. D. Taylor and I. H. Page.—p. 1.
Basic Hemodynamic Changes Produced by Aortic Coarctation of Different Degrees. T. C. Gupta and C. J. Wiggers.—p. 17.
Effects of Arterial and Pulmonary Shunts on Dynamics of Aortic Coarctation. T. C. Gupta.—p. 32.
Hepatorenal Factors in Circulatory Homeostasis: IV. Tissue Origins of Vasotropic Principles, VEM and VDM, Which Appear During Evolution of Hemorrhagic and Tourniquet Shock. E. Shorr, B. W. Zweifach, R. F. Furchgott and S. Baez.—p. 42.
*Studies on Effect of Oral and Parenteral Administration of Visammin (Khellin) in Patients with Angina Pectoris. R. C. Scott, A. Iglauer, R. S. Green and others.—p. 80.
Comparison of Coronary Flow Determined by Nitrous Oxide Method and by Direct Method Using Rotameter. D. E. Gregg, F. H. Longino, P. A. Green and L. J. Czerwonka.—p. 89.
Cavity Potentials of Human Ventricles. H. A. Zimmerman and H. K. Hellerstein.—p. 95.
Effect of Posture and of Compression of Neck on Excretion of Electrolytes and Glomerular Filtration: Further Studies. W. N. Viar, B. B. Oliver, S. Eisenberg and others.—p. 105.
Studies on Relation of Diet, Cholesterol and Atheroma in Chickens. J. E. Peterson and A. E. Hirst.—p. 116.
Early Relief of Chest Pain by Ethyl Chloride Spray in Acute Coronary Thrombosis: Case Report. J. Travell.—p. 120.
Patent Ductus Arteriosus. Observations from 412 Surgically Treated Cases. R. E. Gross and L. A. Longino.—p. 125.

Low Sodium Diet in Hypertension.—Corcoran and collaborators tried to answer the following questions: 1. Does sodium restriction, as such, decrease arterial pressure in essential hypertension? 2. Does the rice diet depend for its effect on sodium restriction or has it some other basis? 3. What is the minimum effective sodium restriction and how long must it be maintained before one can determine whether a patient will respond to such treatment? 4. Can low sodium diet therapy be used under the conditions of outpatient office practice? Studies on 14 patients showed that roughly one fourth of the patients with severe essential hypertension react favorably to sodium restriction. The rice diet is in effect a practical low sodium diet, the hypotensive effect of which is dependent on sodium restriction. In the absence of azotemia it seems unlikely that the concurrent protein deprivation has an added beneficial effect, although with this diet it is possible to maintain nitrogen balance and even to conserve a protein reserve. The minimum sodium restriction necessary for a response per-

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mitted an intake of about 0.5 Gm. sodium daily, in patients with "salt-losing" renal disease. This restriction must be maintained for four weeks for a conclusive test of responsiveness. Although four of 14 outpatients responded favorably to sodium restriction, responses could be maintained only in two. Outpatient low sodium diet therapy is difficult and is often impractical. The experience the authors had with the inpatient and outpatient series leads them not to reject as invalid observations on the effect of low sodium diets that are not controlled by frequent determinations of urinary sodium output.

Visammin (Khellin) in Patients with Angina Pectoris.—To evaluate further the use of visammin (khellin) in the treatment of angina pectoris, Scott and co-workers studied both subjective and objective data in 20 patients with this disease. There was a control period of observation and alternate periods of placebo and visammin therapy. The total period of observation averaged six months for each patient. Tablets containing 40 mg. of visammin were used for the oral medication. The dosage of visammin for intramuscular injection varied between 100 and 400 mg. The authors found that only four of the 20 patients had a significant reduction in the number of anginal attacks while receiving visammin orally; however, 11 stated that their pains were less severe and that they were able to do more work. There was questionable improvement in performance as measured by the exercise tolerance test in two of nine patients studied after orally administered visammin. Cardiac output as measured by the ballistocardiograph following the intramuscularly administered visammin increased in only one of eight patients. Pressor and depressor blood pressure reflexes induced by tilting showed no changes after parenterally administered visammin in six cases studied. Undesirable side effects were frequently encountered and were commoner with daily dosages of 120 mg. or more. The authors believe that visammin is valuable in the treatment of angina but that at present the high incidence of undesirable side effects often prevents a dose adequately high for benefit.

Diseases of Chest, Chicago

19:1-112 (Jan.) 1951

Decortication of Unexpandable Pneumothorax Lung. D. H. Waterman and S. E. Domm.—p. 1.
Superior Vena Caval System Obstruction. M. C. McCord, P. Edlin and M. Block.—p. 19.
Leukocytic Pattern During Streptomycin Treatment of Pulmonary Tuberculosis. L. S. Arany.—p. 28.
Effect of Pneumoperitoneum on Electrocardiogram: Study of Results Obtained with Standard and Unipolar Leads. A. Pollak.—p. 36.
*Role of Bronchoscopy in Artificial Pneumothorax. G. R. Hodell.—p. 58.
Bronchography in Pulmonary Tuberculosis. P. Rabinowitz and I. S. H. Harper.—p. 66.
Complications of Pneumothorax and Pneumolysis. L. H. Strug and R. M. Shepard.—p. 78.
Kartagener's Triad: Review of Literature and Report of Case. H. S. Zuckerman and L. R. Wurtzebach.—p. 92.
Tuberculosis and Private Health. J. D. Wasserug.—p. 98.
Address. M. Cañizares.—p. 104.
Modification of Jackson Bronchoscope. A. A. Carabelli.—p. 107.
Present Status of Vaccination in Tuberculosis Control Programs: Report of Council on Management and Treatment of Diseases of Chest, American College of Chest Physicians.—p. 110.

Bronchoscopy in Artificial Pneumothorax.—Hodell reports three cases in which large cavities remained despite satisfactory pneumothorax. Thoracotomy was not possible in two of these cases of far advanced pulmonary tuberculosis because of serious involvement of the contralateral lung. Surgical aid was not available in the third. Uneventful recovery with closure of the cavities and management of the coexisting endobronchial disease was effected by bronchoscopic therapy in all three cases. The author also refers to 15 cases of the above condition that occurred during 1944 and 1945 in a group of 217 pneumothorax patients. Complete recovery was effected in all 15 cases. These recoveries were substantiated by a four year follow-up. No cases treated after 1946 were included, because of an insufficiently long follow-up period. However, three cases are cited in which recovery was only apparent and recurrence of cavitation took place after 6, 10 and 12 months respectively. The author discusses the importance of bronchoscopy as a means of identifying and removing obstructive bronchial plugs in the pneumothorax patient, as a means of identifying the source of a positive sputum and identifying and treating an active endobronchial lesion.

Georgia Medical Association Journal, Atlanta

40:1-40 (Jan.) 1951

Significance and Management of Cardiac Arrhythmia. B. Logue.—p. 1.
Differential Diagnosis and Treatment of Coronary Diseases. P. T. Russell.—p. 6.
*Practical Aspects of Treatment of Dicumarol Intoxication. D. F. James.—p. 8.
Methods and Uses of Cardiopulmonary Function Tests. R. G. Ellison.—p. 12.
Streptomycin Failures in Tuberculosis. R. F. Payne.—p. 20.
*Bentyl Hydrochloride: A New Antispasmodic Agent. C. W. Hock.—p. 22.
Fibrosarcoma Developing in Heavily Irradiated Skin. C. B. Stewart and W. J. Pendergrast.—p. 24.
Internal Drainage of Pancreatic Cysts: Utilization of the Roux Y Principle. W. G. Whitaker Jr.—p. 25.

Treatment of Dicumarol® Intoxication.—James describes experiences with bishydroxycoumarin (dicumarol®), which was given orally to 101 patients in what has become a standard method of administration, i. e., an initial oral dose of 300 mg. followed by successive daily doses of 200 mg. until the prothrombin concentration is equal to or less than that of control plasma diluted with isotonic sodium chloride solution to 20 per cent. In 26 patients, five days or more elapsed before the prothrombin times became lengthened to beyond that of 20 per cent control plasma. A similar lag period occurs before the recovery from bishydroxycoumarin effect ensues. The fact that frequent prothrombin determinations are necessary during prothrombin therapy is another disadvantage. Bishydroxycoumarin intoxication may be manifested in one of two ways: (1) by bleeding (probably because of the production of hypoprothrombinemia); (2) by excessive hypoprothrombinemia without hemorrhage. The author's experience has not borne out the idea that bleeding due to bishydroxycoumarin intoxication is easily correlated with the degree of hypoprothrombinemia. He observed at least five patients in whom this drug produced hemorrhage and in whom the prothrombin time was not prolonged beyond that of 10 per cent control plasma. During the same period, about 12 patients were seen whose prothrombin times were prolonged far beyond that of 10 per cent control plasma and who did not bleed at all. Factors other than the concentration of prothrombin play a part; these include the vascular status, the role of previous trauma to blood vessels and the state of nutrition. The author was unable to corroborate the widespread belief that the injection of about 70 mg. of menadione sodium bisulfite (vitamin K) is sufficient to counteract excessive hypoprothrombinemia or bleeding caused by bishydroxycoumarin. He did, however, obtain remarkable results with vitamin K_1 oxide with an intravenous dose of over 500 mg. He hopes that this substance soon will be generally available. The administration of fresh or stored blood and probably also plasma only temporarily shortens the prothrombin time, which soon reverts to the pretransfusion level.

A New Antispasmodic Agent.—It has been demonstrated in animal experiments that the new compound bentyl hydrochloride® (beta-diethylaminoethyl 1-cyclohexylcyclohexanecarboxylate hydrochloride) possesses both a parasympathetic depressant (atropine-like) and musculotropic (papaverine-like) action on the smooth musculature of the gastrointestinal tract. Hock administered this drug to 67 patients with such gastrointestinal complaints as functional bowel distress, peptic ulcer, chronic pancreatitis and gastroenteritis. The usual dosage was 10 or 20 mg. three or four times daily, with or without 15 to 30 mg. of phenobarbital. The drug was well tolerated in 66 of 67 patients and was stopped in only one patient who showed intolerance to other drugs also. Bentyl hydrochloride® appears to be more effective than the belladonna group of antispasmodics and has the advantage of virtual freedom from psychoplegia, mydriasis and xerostomia.

GP (J. Am. Acad. Gen. Practice), Kansas City, Mo.

3:1-180 (Feb.) 1951

ACTH and Cortisone—Miracle Therapy or Medical Tool? J. Dewitt.—p. 33.
Immediate Care of Thoracic Injuries. P. C. Samson.—p. 39.
Progress in Treating Cancer of Cervix. R. E. Fricke.—p. 49.
Office Gynecology. J. P. Greenhill.—p. 55.
Symptomatic Management of Pulmonary Tuberculosis. M. J. Sokoloff.—p. 67.

Hawaii Medical Journal, Honolulu

10:159-226 (Jan.-Feb.) 1951

Observations on Carcinoma of Stomach in Hawaii: Study of 140 Consecutive Cases Coming to Surgery. J. E. Strode.—p. 173.
Modern Psychiatric Hospital. D. Blain.—p. 177.
Rheumatic Fever in Hawaii. A. Connor and T. Yoshina.—p. 181.
Subdural Hematoma. Complications and Surgical Treatment: Report of 51 Cases. R. B. Cloward.—p. 183.
Alternating Bidirectional Tachycardia. M. E. Berk and H. Gotshalk. —p. 186.

Indiana State Medical Assn. Journal, Indianapolis

44:1-92 (Jan.) 1951

Anesthesiology—Its Economics. R. M. S. Barrett.—p. 17.
Construction of Permanent Skin-Covered Ileostomy. C. C. Kissinger. —p. 20.
Value of External Carotid Angiography in Surgery of Brain Tumor: Report of Case. W. R. Chambers.—p. 23.
Volvulus of Cecum: Report of Two Cases. M. B. Welborn.—p. 26.

Journal of Bone and Joint Surgery, Boston

33A:1-278 (Jan.) 1951. **Partial Index**

*Late Results in Legg-Perthes Disease. E. R. Mindell and M. S. Sherman. —p. 1.
Cure of Experimental Scoliosis by Directed Growth Control. I. W. Nachlas and J. N. Borden.—p. 24.
Congenital Anomalies of Hand. A. J. Barsky.—p. 35.
Use of Metallic Femoral Head. L. T. Peterson.—p. 65.
Lesions of Musculotendinous Cuff of Shoulder: IV. Some Observations Based upon Results of Surgical Repair. H. L. McLaughlin and E. G. Asherman.—p. 76.
Shelf Operation for Congenital Subluxation and Dislocation of Hip. M. E. Anderson and W. H. Bickel.—p. 87.
Localized Neurofibromatosis with Associated Overgrowth of Extremity: Equalization of Limb Length Following Epiphyseal Arrest. J. T. Tucker and E. B. Carpenter.—p. 103.
Surgical Management of Chronic Osteomyelitis by Saucerization, Primary Closure, and Antibiotic Control: Preliminary Report on Use of Aureomycin. J. Buchman and J. E. Blair.—p. 107.
Tuberculosis of Sacro-Iliac Joint: Review of 75 Cases. S. T. Soholt. —p. 119.
Tuberculosis of Hip: Follow-Up Study of 58 Cases with Special Reference to Fusion Results in Young Children. H. I. Yu.—p. 131.
Giant-Cell Tumor of Bone: Current Status of Problems in Diagnosis and Treatment. L. Lichtenstein.—p. 143.
Resection of Dorsal Vertebrae in Congenital Scoliosis. P. Wiles.—p. 151.
*Effects of Short-Wave Diathermy on Bone Repair. W. J. Hutchison and B. D. Burdeaux Jr.—p. 155.
Natural Course of Osteoid Osteoma. E. Moberg.—p. 166.
*Congenital Dislocation of Hip: Part II. Results of Open Reduction as Seen in Early Adult Period. W. K. Massie and M. B. Howorth.—p. 171.
Medical-Care Program of National Foundation for Infantile Paralysis, Inc. H. E. Van Riper.—p. 198.
Vitamin-Resistant Rickets. H. E. Pedersen and H. R. McCarroll.—p. 203.

Late Results in Legg-Calvé-Perthes Disease.—To evaluate the results of various types of treatment in Legg-Calvé-Perthes disease (osteochondritis of the upper femoral epiphysis) the authors studied 72 patients (78 involved hips). Eighty-one per cent of the patients were followed for more than six years, and 28 per cent were followed for over 16 years. Thirteen patients had no treatment, 46 had early treatment and 14 had late treatment. Treatment was regarded as early if it was started while the femoral head was still fairly intact with little or no deformity and no significant change in the femoral neck. Approximately half the treated patients were treated by bed rest, traction or immobilization. The other half used crutches or an ischial weight-bearing brace, which removed all weight from the affected extremity. There was no difference in the results obtained in those who used crutches or a brace and those who were kept in bed. Satisfactory results (freedom from symptoms of deformity) were obtained in 72 per cent of the patients who were treated early, 36 per cent of those treated late and 23 per cent of those receiving no treatment. Fair results (slight shortening and atrophy of the affected extremity and occasional pain) were obtained in 17 per cent of the patients treated early, 14 per cent of those treated late and 8 per cent of the untreated group. Poor results were obtained in the remainder. There was much variation in the course of the disease in different patients. In general, the earlier the onset of the disease the better the prognosis. Pronounced changes in the femoral neck and lateral expansion or central depression of the femoral head indicated a poor prognosis. When arrest of the capital femoral epiphyseal cartilage plate occurred, this contributed to the deformity. Even with gross changes in the roentgenogram there may be few or no symptoms in early adult life, but later progressive disability occurs. Therefore, treatment should be begun early. Removal of weight from the affected limb by the use of crutches seems to be sufficient treatment in a cooperative patient with unilateral involvement.

Effects of Short Wave Diathermy on Bone Repair.—The value of the use of diathermy to stimulate the repair of fractures has been discussed by many, but since no experimental observations were available, Hutchison and Burdeaux determined the effects of short wave diathermy in clinical or subclinical doses on bone grafts and fracture healing. They found that diathermy in repeated clinical doses delays healing of fractures in rabbits and the union of bone grafts in dogs. The new bone formation and callus are of poor structural quality. Diathermy causes a decrease in the formation of osteoporosis following bone trauma in dogs and rabbits. Since healing is delayed when osteoporosis is minimal, perhaps osteoporosis is an essential factor in the process of normal bone repair. The continued use of diathermy in clinical doses causes edema of the skin, subcutaneous tissues and muscles in rabbits. There is stimulation of hair growth in rabbits within four days following the use of diathermy. Diathermy greatly delays the healing of surgical wounds in dogs and rabbits.

Congenital Dislocation of Hip: Results of Open Reduction.—A method of open reduction for congenital dislocation of the hip, described by Farrell and Howorth in 1935, was used successfully in 77 per cent of 122 hips. The results of treatment in early adulthood of 58 of the hips included in the earlier report are presented here. The average follow-up period was 18 years. From the symptomatic point of view 65 per cent were normal, 20 per cent had fair results and 15 had unsatisfactory results; with regard to the physical status 39 per cent were normal, 34 per cent had fair results and 27 had unsatisfactory results; roentgenologically 17 per cent were normal, 22 had fair results and 61 had unsatisfactory results. The optimum roentgenographic grade was attained two years after reduction in 66 per cent of the hips and by puberty in 85 per cent. Roentgenographic follow-up of the hips of children between the ages of five and eight shows trends toward the eventual adult result, a fact that is of value in determining further treatment. Vascular changes were seen in 41 per cent of the femoral heads, and in 81 per cent of such hips the roentgenographic rating was below 70 per cent of normal. It is again proposed that an initial capsular relaxation is the primary abnormality in congenital dislocation of the hip. Subluxation and dislocation are the result of the mechanical forces applied to the hip with a relaxed capsule. The acetabular changes are secondary. Postreduction subluxation jeopardizes the development of a normal adult hip. Increase of the subluxation means an unsatisfactory result. On the other hand, if perfect reduction is obtained and maintained an excellent result is assured, provided there are no vascular changes in the epiphysis.

Journal of Clinical Investigation, Cincinnati

29:1559-1676 (Dec.) 1950

Metabolism of Women During Reproductive Cycle: XVII. Changes in Electrophoretic Patterns of Plasma Proteins Throughout Cycle and Following Delivery. M. N. Coryell, E. F. Beach, A. R. Robinson and others.—p. 1559.
Studies of Pulmonary Capacity and Mixing with Nitrogen Meter. W. A. Wolfe and L. D. Carlson.—p. 1568.
Treatment of Nephrosis with Cortisone. J. A. Luetscher Jr. and Q. B. Deming.—p. 1576.
Extent of Enzymatic Degradation of Desoxyribonucleic Acid (DNA) in Purulent Exudates by Streptodornase. S. Sherry and J. P. Goeller. —p. 1588.
Source of Gastric Lysozyme. S. J. Gray, R. W. Reifenstein, J. C. G. Young and others.—p. 1595.
Left Ventricular Pressures in Patients with Aortic Insufficiency Studied by Intracardiac Catheterization. H. A. Zimmerman.—p. 1601.
Tagging of Red Cells and Plasma Proteins with Radioactive Chromium. S. J. Gray and K. Sterling.—p. 1604.
Determination of Circulating Red Cell Volume in Man by Radioactive Chromium. K. Sterling and S. J. Gray.—p. 1614.
Electrophoretic Studies of Plasma and Serum Proteins in Sickle Cell Anemia. R. L. Fenichel, J. Watson and F. Eirich.—p. 1620.
Acetylation Studies in Human Subjects with Metabolic Disorders. H. Gershberg and W. J. Kuhl Jr.—p. 1625.
Insulin Sensitivity of Patients with Diabetes Mellitus. P. Kirketerp. —p. 1633.
Association of Lipoproteins with Inhibition of Streptolysin S by Serum. G. H. Stollerman, A. W. Bernheimer and C. M. MacLeod.—p. 1636.

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Journal of Experimental Medicine, New York

93:99-196 (Feb.) 1951

Studies on Immunity in Anthrax: I. Variation in Serum T-Agglutinin During Anthrax Infection in Rabbit. G. G. Wright and J. B. Slein. —p. 99.
Adsorption of Proteins on Erythrocytes Treated with Tannic Acid and Subsequent Hemagglutination by Antiprotein Sera. S. V. Boyden. —p. 107.
Microspectrophotometric Study of Red Cell Nuclei During Pyknosis. R. Korson.—p. 121.
Comparison of Growth Curves of Adapted and Unadapted Lines of Influenza Virus. F. M. Davenport and T. Francis Jr.—p. 129.
Dependence of Pathological Lesion upon Multiplication of Pneumonia Virus of Mice (PVM). Kinetic Relation Between Degree of Viral Multiplication and Extent of Pneumonia. F. L. Horsfall Jr. and H. S. Ginsberg.—p. 139.
Characteristics of Multiplication Cycle of Pneumonia Virus of Mice (PVM). H. S. Ginsberg and F. L. Horsfall Jr.—p. 151.
Therapy of Infection with Pneumonia Virus of Mice (PVM). Effect of Polysaccharide on Multiplication Cycles of Virus and on Course of Viral Pneumonia. H. S. Ginsberg and F. L. Horsfall Jr.—p. 161.
Localization of Antigen in Tissue Cells: VI. Fate of Injected Foreign Proteins in Mouse. A. H. Coons, E. H. Leduc and M. H. Kaplan. —p. 173.
*Splanchnic Removal of Bacteria from Blood Stream of Leukopenic Rabbits. G. P. Kerby and S. P. Martin.—p. 189.

Bacteremia in Leukopenia.—The number of bacteria present in the blood stream is determined by the rate at which local tissue defenses permit their entry, by the species of bacteria and by the rate at which the bacteria are removed from the blood stream. It is well known that in the absence of leukocytes there is less destruction of bacteria in the tissues, so that large numbers of organisms may enter the blood stream in severe leukopenic states. The quantitative removal of bacteria from the blood stream has been studied previously by a method of continuous intravenous infusion of bacteria combined with a technique of venous catheterization for obtaining repeated samples of blood for culture from the various organs of the intact animal. The results showed that bacteria are removed from the blood stream predominantly during their circulation through the organs drained by the hepatic vein (the splanchnic area). The data presented here demonstrate that profound leukopenia does not interfere with the efficiency of the splanchnic removal of bacteria from the circulating blood of the intact rabbit. In rabbits subjected to profound damage of the blood-forming tissues by the use of benzene and mechlorethamine hydrochloride, no impairment of efficiency in the splanchnic removal of Micrococcus aureus from the blood stream could be demonstrated by a method involving catheterization of the hepatic vein. Evidence continues to indicate that bacteremia cannot be maintained unless the organisms are introduced constantly into the blood stream from some endogenous source. The importance of the leukocyte in the establishment and clearing of bacteremia appears to lie in its phagocytic activities at the local source of the bacteremia rather than in any quantitatively significant phagocytosis of organisms circulating in the blood stream. Therefore, in the leukopenic state attention should be directed toward identification and eradication of the local source of organisms.

Journal-Lancet, Minneapolis

71:1-42 (Jan.) 1951

North Dakota Medicine—A 70-Year Span. H. E. French.—p. 2.
*Blood Sugar Methods in Clinical Medicine: Study of Folin-Wu, Somogyi-Nelson and Wilkerson-Heftmann Blood Sugar Determinations in 100 Subjects. E. A. Haunz and D. C. Keranen.—p. 9.
Pheochromocytoma: Report of Case. W. E. G. Lancaster and W. H. Johnston.—p. 17.
Cardiovascular Management of Prostatectomy Patients. A. C. Grorud. —p. 21.
Dr. Fred G. Lundy of Dakota Territory. R. M. Hewitt.—p. 23.
Subdural Hematoma Complicating Meningitis. R. B. Tudor, C. K. Olson, and R. B. Tudor.—p. 28.
Extrarenal Azotemia. R. O. Goehl.—p. 29.

Blood Sugar Methods.—The authors made 400 fasting blood sugar determinations on 100 subjects to ascertain the limitations, reliability and problems in clinical interpretation of values obtained with the Folin-Wu procedure, the Somogyi-Nelson procedure and the Wilkerson-Heftmann rapid blood sugar screening test. Sixty-six subjects were diabetic, and 34 were normal. For the Folin-Wu and Somogyi-Nelson procedures, venous blood was used, while Wilkerson-Heftmann determinations were carried out on finger tip (arterial) blood. Comparison of the Folin-Wu and Somogyi-Nelson methods provided evidence that the former procedure may yield values from 2 mg. per 100 cc. to 72 mg. per 100 cc. higher than the actual value for blood dextrose, owing to unpredictable quantities of nondextrose-reducing substances in the blood. Folin-Wu values are therefore unreliable, particularly in dextrose tolerance tests, in insulin-resistant cases and in so-called "brittle" diabetics. In 200 Wilkerson-Heftmann rapid screening blood sugar tests, demonstrable inaccuracies ranging from + 12 mg. per 100 cc. to —30 mg. per 100 cc. occurred in only seven instances. It is a curious paradox that a five minute blood sugar screening test made with finger tip blood has a much higher degree of accuracy than the 40 minute Folin-Wu procedure, which requires venipuncture. The Folin-Wu and similar blood sugar methods that include nonglucose substances should be abandoned. The Wilkerson-Heftmann rapid screening test for blood sugar has potentialities of application well beyond simple diabetes detection tests. Its use is recommended for the emergency distinction between diabetic and insulin coma, for the office management of diabetic patients and as a routine procedure in all unexplained cases of coma. It should be a standard procedure in every routine physical "check-up."

Journal National Malaria Society, Columbia, S. C.

9:285-406 (Dec.) 1950. **Partial Index**

*Primaquine, SN 13272, New Curative Agent in Vivax Malaria: Preliminary Report. J. H. Edgcomb, J. Arnold, E. H. Yount Jr. and others. —p. 285
Strain Differences in Plasmodium Gallinaceum Brumpt: I. Differences in Behavior of Exoerythrocytic Forms of Blood-Passaged (BI) and Sporozoite-Passaged (SP) Strain of Plasmodium Gallinaceum. J. Greenberg, H. L. Trembley and G. R. Coatney.—p. 320.
Studies on Relapses in Blood-Induced Infections from Plasmodium Malariae and Plasmodium Cynomolgi. A. Corradetti and F. Verolini. —p. 327.
Observations on Mechanism of Blackwater Fever: Experimental Study in Monkey. R. H. Ridgon and J. E. Quattlebaum.—p. 332.
Precipitin Technique for Determining Species of Host Blood in Mosquitoes—Modifications and Improvements. J. H. Schubert and M. H. Kelly.—p. 341.
Comparative Susceptibility of Anopheles Quadrimaculatus and Two Strains of Anopheles Albimanus to Panama Strain of Plasmodium Falciparum. G. M. Jeffery, D. E. Eyles and M. D. Young.—p. 349.
Further Report on Use of Chlorguanide (Paludrine) to Suppress Malaria Prevalence in Southern Formosan Villages. J. H. Paul, R. B. Watson and K. C. Liang.—p. 356.
Studies in Human Malaria. W. C. Cooper, G. R. Coatney, G. M. Jeffery and C. A. Imboden Jr.—p. 366.
Epidemiological Appraisal of Reported Malaria in the United States from 1947 Through 1949. G. E. Quinby.—p. 397.

New Curative Agent in Vivax Malaria.—A new antimalarial drug, primaquine (SN 13,272), has been found to be superior to both pamaquine and isopentaquine oxalate because it will cure severe vivax malaria infections in doses that are relatively nontoxic. These drugs were compared in controlled therapeutic experiments. Hospitalized white male volunteers were given a standard heavy inoculation of the Chesson strain of vivax malaria. After clinical symptoms appeared they were treated with varying doses of the test drugs. Another group of patients were treated who relapsed following therapy with other drugs. In this paper the results of primaquine therapy are reported and compared with previous studies on the other drugs. When primaquine was given alone in six divided doses daily, some curative effect was demonstrated in doses as low as 22.5 mg. of the base daily. This was greatly enhanced by concurrent administration of 1.64 Gm. of quinine base daily. The latter regimen prevented relapse in almost 100 per cent of the cases during an observation period of six months to one year. Increase in the dose of primaquine to 60 mg. daily increased the toxicity without improving the therapeutic results. Toxic effects consisted of nausea, vomiting, abdominal cramps and methemoglobinemia. On an equal weight basis, primaquine was about four times as active as pamaquine and isopentaquine. It had the additional advantage that it was effective prophylactically and therapeutically when given in a safe single daily dose.

Journal of National Medical Association, New York

43:1-72 (Jan.) 1951. **Partial Index**

Role of Gastroscopy in Diagnosis of Gastric Pathology. D. J. Thompson. —p. 1.
*Studies of Atypical Pneumonia. R. O. Muether and A. H. Ishii.—p. 7.
Perforating Gunshot Wounds of Abdomen. J. E. White and C. R. Drew. —p. 14.
Pseudocyst of Pancreas—Report of Case. W. Rienhoff Jr., R. L. Jackson and M. W. Moore Sr.—p. 28.
Evaluation and Physical Medicine Treatment of Arteriosclerotic Peripheral Vascular Disease. B. S. Troedsson.—p. 31.
Incidence of Recurrence of Hernias Experienced at the Provident Hospital, Baltimore, Maryland, 1938-1948. E. C. Walden Sr. and H. C. Welcome. —p. 37.

Atypical Pneumonia.—This report presents observations on 61 patients with atypical pneumonia treated during the late winter and spring at two St. Louis hospitals. The symptoms were chiefly fever, cough, chest pain, anorexia, malaise and chills. The fever usually lasted less than five days, but complete recovery was sometimes delayed for more than one month. Fine crepitant rales heard after coughing or deep inhalation may be the only physical signs. Even in some cases in which roentgenoscopy revealed pulmonary infiltration, physical examination revealed no abnormalities. Pleural effusion may be demonstrated by x-ray examination, but thoracentesis is rarely required, because such fluid is usually absorbed rapidly as the patient recovers. The leukocyte count is usually moderately increased or normal, leukopenia and lymphocytosis being the exception rather than the rule. A shift to the left in the Schilling differential count is noted early, and eosinophils may be present throughout the disease. Leukopenia, if it occurs, will be noted at the onset of convalescence. Serological studies were not helpful, and cold agglutinins appeared only rarely in the cases reported here. All atypical pneumonias are not caused by the same agent. Different etiological agents perhaps explain the differences in clinical and laboratory aspects, the presence or absence of cold agglutination and antibodies against Streptococcus MG being a case in point. Some authors find these immunological changes in 50 to 75 per cent of their cases, while others find them in only a few. The virus of herpes, psittacosis, influenza, Newcastle disease, lymphocytic choriomeningitis, the rickettsia of Q fever and possibly Streptococcus viridans and nonhemolytic streptococci have all been implicated in atypical pneumonia, but the authors feel that less than 20 per cent of atypical pneumonias can be attributed to such agents.

Journal of Nutrition, Philadelphia

43:1-192 (Jan.) 1951. **Partial Index**

Studies on Vitamin B_{12} Content of Feedstuffs and Other Materials. H. T. Peeler, H. Yacowitz, C. W. Carlson and others.—p. 49.
Evaluation of Five Partially Purified Proteins by Nitrogen Balance in Mature Dogs, Including Study of Antitryptic Activity of Egg White. A. F. Morgan, C. N. Hunt, L. Arnrich and E. Lewis.—p. 63.
Use of Chromic Oxide as Index Material in Digestion Trials with Human Subjects. M. I. Irwin and E. W. Crampton.—p. 77.
Studies on Nature of Nutritional Deficiencies of Wheat Gluten Meal. E. W. Lewis Jr., C. A. Elvehjem and E. B. Hart.—p. 113.
Effect of Some Combinations of Human Foods on Growth and Health of Laboratory Rat. E. C. Callison, E. Orent-Keiles and R. U. Markower. —p. 131.
*Effect of Ingestion of Alcohol on Storage and Excretion of Thiamine. A. W. Wertz, P. S. Van Horn and L. E. Lloyd.—p. 181.

Effect of Ingestion of Alcohol on Thiamine.—Reports have been published that suggest that the metabolism of alcohol does not require as much thiamine as the metabolism of an isocaloric amount of carbohydrate or that alcohol may have a "sparing" action on thiamine. A study of the urinary thiamine and pyruvic acid excretion and the tissue storage of thiamine in paired rats with and without alcohol in the ration is reported in this paper. Results suggested that the utilization of the additional calories supplied by the alcohol did not demand an amount of thiamine greater than that needed for utilization of the calories in the basal ration. However, utilization of the same number of additional calories supplied in the form of dextrose caused a significantly greater depletion of the thiamine stores of the liver. Thus these data seem to support the view that the utilization of alcohol fed as a supplement to the ration does not involve an increased need for thiamine.

Journal of Pediatrics, St. Louis

38:1-146 (Jan.) 1951

Retrolental Fibroplasia: Clinical Statistics from the Premature Center of the Charity Hospital of Louisiana at New Orleans. A. L. Exline Jr. and M. R. Harrington.—p. 1.
Later Status of Juvenile Diabetics. C. W. Daeschner, R. W. Deisher and A. F. Hartmann.—p. 8.
Clinical Study Concerning Value of Biolac: Effect of Changes Introduced in New Improved Biolac upon Growth of Young Infants. S. Hazard, C. A. Smith and F. Denton.—p. 18.
Methylene Blue in Treatment of Methemoglobinemia in Premature Infants Caused by Marking Ink: Report of Eight Cases. J. N. Etteldorf. —p. 24.
Relationship Between Infant Feeding Experience and Later Behavior. N. R. Newton.—p. 28.
*Evaluation of Carbohydrate-Phosphoric Acid Solution in Management of Vomiting. J. E. Bradley, L. Proutt, E. R. Shipley and R. H. Oster. —p. 41.
Electrocardiographic Changes Occurring During Course of Replacement Transfusions. R. A. Furman, H. K. Hellerstein and V. Startzman. —p. 45.
*Results of Histoplasmin Skin Testing in Children from St. Louis, Mo., Area. J. F. Lynch and E. B. Alpern.—p. 51.
Progressive Diaphyseal Dysplasia (Engelmann's Disease). J. B. Gillespie and R. D. Mussey.—p. 55.
Ineffectiveness of Aureomycin in Preventing Primary Vaccinia Reaction. R. H. High and C. B. Reiner.—p. 60.
Thymectomy and ACTH in Lymphatic Leucemia. A. M. Earle, W. A. Reilly and G. O. Dean.—p. 63.
Total Absence of Cerebral Hemispheres: Report of Two Cases. E. Eberling Johnson, M. Warner and J. P. Simonds.—p. 69.

Carbohydrate Phosphoric Acid Solution in Vomiting.—The effects of an orally administered invert sugar-phosphoric acid solution on isolated strips of rabbit gastrointestinal muscle, including sections of the pyloric portion of the stomach, were studied. Results of the experiments showed a sustained reduction in contraction rate without complete loss of tone and with a pronounced reduction in amplitude. It became evident that to prevent contraction of gastrointestinal smooth muscle, the test solution had to be kept within an optimal pH range. Clinical trial of the oral preparation was made on 246 infants and children with nausea, vomiting or regurgitation. The carbohydrate phosphoric acid solution was given in doses of 10 to 15 cc. every 15 minutes for four doses. Vomiting ceased in all the 172 patients with epidemic vomiting. Of 43 infants suffering from regurgitation, 29 responded favorably. These infants had previously failed to respond to atropine, phenobarbital or other preparations. Fifteen of 17 patients with toxic vomiting responded favorably. Motion sickness was prevented in all of 11 children regularly subject to nausea when traveling in vehicles. Three patients with vomiting due to pyloric stenosis did not respond. These results strongly suggest that carbohydrate phosphoric acid solution is effective in restoring cellular utilization of carbohydrate by repairing a defect in the continuity of carbohydrate metabolism. The treatment described offers a simple, effective method of controlling vomiting in many common conditions.

Histoplasmin Skin Testing.—Histoplasmin skin tests were performed on 500 infants and children. A filtered broth culture of Histoplasma capsulatum, diluted 1:1000 with isotonic sodium chloride solution was used for intradermal injections. Seventy-three (14.6 per cent) of the 500 children gave positive reactions to intradermal histoplasmin. Only five (1.9 per cent) of the children aged less than 3 were observed to be histoplasmin positive. The incidence of positive histoplasmin reactions increased rapidly with age up to 10 years. A higher incidence of positive skin reactions was observed in male than in female children. The high incidence of chronic disease among positive histoplasmin reactors was noted. Of 43 patients with positive histoplasmin reactions, 30 (69.7 per cent) lived in rural areas and in small towns. All the positive reactors aged less than 3 resided in small towns or rural areas. These facts suggest that the agent giving rise to positive histoplasmin reactions might be more prevalent in rural areas. Observations on chest x-rays of positive reactors agreed with many previous observations that showed that a large percentage of pulmonary calcifications are not associated with a positive tuberculin skin reaction or with clinical evidence of active tuberculosis.

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Progressive Diaphyseal Dysplasia.—Only eight cases of progressive diaphyseal dysplasia (Engelmann's disease) are reported in the literature. The patients' ages ranged from 4 to 28 years. The cause of progressive diaphyseal dysplasia is unknown. The syndrome is characterized by progressive symmetrical enlargement and cortical thickening in the diaphyses of long bones. The clinical observations include muscular weakness, a waddling gait, failure to gain weight properly and, occasionally, neurological variations, which suggest that more than simple maldevelopment of bone may be involved in this dystrophy syndrome. The authors report an additional case in a girl aged 33 months, who was followed for two and a half years. Her history was normal except that she did not walk until 18 months of age, at which time a waddling gait was noted by the parents. This peculiar gait, wide based and without a limp, persisted. There was no clinical evidence of rickets. The child was well developed and fairly well nourished at the first examination. At the last follow-up examination she appeared generally undernourished, walked stiffly with legs apart in a straddle type of gait. Complaint of leg pain was minimal. Moderate decrease of internal rotation of both hips was present. There was mild lumbar lordosis. Roentgen studies demonstrated involvement of all long bones, the skull and the clavicles.

Journal of Urology, Baltimore

65:1-162 (Jan.) 1951

Fibrosarcoma Arising in Hematonephrotic Sac of Lower Division of Double Kidney. F. K. Garvey, W. A. Cline and C. C. Carpenter.—p. 1.
Renal Angioma: Suspected Bilateral Involvement. B. E. Paletz and G. Sewell.—p. 9.
Hemangioma of Kidney. A. J. Butt and J. Q. Perry.—p. 15.
*Metaplasia of Ureteral Epithelium Resulting in Intestinal Mucosa and Adenocarcinomatous Transformation: Report of Two Cases. N. H. Jacob Jr. and W. Mau.—p. 20.
Surgical Management of Painful Bladder. J. P. Bourque.—p. 25.
Statistical and Analytic Review of Final Results of Transurethral Resection for Cord Bladder. J. L. Emmett, D. D. Albers and R. E. Anderson.—p. 36.
Parasitic Fibromyoma of Bladder. W. P. Kleitsch.—p. 60.
Carcinoma of Bladder: Clinical Therapeutic and Pathologic Aspects of 135 Cases. R. K. Royce and L. V. Ackerman.—p. 66.
Mucoid Adenocarcinoma of Urachus Invading Bladder. S. P. Hurwitz, E. B. Jacobson and H. H. Ottenstein.—p. 87.
Postoperative Urinary Incontinence. E. Davis.—p. 93.
*Bacterial Endocarditis as Complication of Transurethral Prostatic Resection. W. A. Merritt.—p. 100.
Urethral Diverticula in Paraplegics. V. A. Pate Jr. and R. C. Bunts.—p. 108.
Cholesteatoma of Epididymis. L. J. Pingree and D. E. Brown.—p. 126.
Treatment of Malignant Tumors of Testis. D. D. Merren, S. A. Vest and C. H. Lupton Jr.—p. 128.
Tumors of Spermatic Cord. J. L. Brockow and G. Gummess.—p. 136.
Case of Prepenile Scrotum. L. F. Huffman.—p. 141.
Secondary Tumors of Genito-Urinary Tract. M. E. Klinger.—p. 144.
Allergy and Drug Hypersensitivity of Urinary Tract. J. S. Eisenstaedt.—p. 154.
New Fenestrated Trocar for Introduction of Balloon Catheters in Cystostomy, Nephrostomy and Pyelostomy. M. Campbell.—p. 160.

Metaplasia of Ureteral Epithelium into Intestinal Mucosa.—The histories of two patients are presented in whom epithelium of the intestinal type was found in the ureter. The first patient, a man aged 36, had undergone nephrectomy in 1943 because of renal calculi and chronic urinary infection. The patient's poor condition at that time precluded the removal of the ureter. In 1947, when he was hospitalized again, roentgen examination revealed a large calculus in the remaining ureteral stump. A right ureterectomy was performed. Microscopic examination of the removed ureter revealed a striking resemblance of the tissue to appendiceal mucosa. In the second patient, a man aged 57, x-ray examination revealed an irregular filling defect and distortion of the ureteropelvic junction on the left. The surgeons found a small, fibrotic, contracted kidney that was bound down by dense fibrous tissue. In the renal pelvis a large calculus could be palpated. A soft tissue mass occupied the lumen and enlarged the upper end of the ureter. The tumor, ureter, renal pelvis and kidney were removed. Sections through the tumor presented the typical picture of adenocarcinoma, and random sections in the renal pelvis revealed glands resembling those seen in the mucosa of the large bowel. The papillary adenocarcinoma was similar to those that arise in intestinal mucosa. The literature on epithelial aberrancy in the urinary tract is briefly reviewed. The authors admit that there is no way of conclusively proving that the presence of intestinal-like epithelium in these two cases may not have been the result of abnormal embryological development. On the other hand, chronic inflammation is such a pronounced feature in both the clinical history and the microscopic picture that it may have more than incidental significance. The authors are inclined to believe that long-standing chronic irritation may be a major factor in stimulating proliferation of transitional epithelium and downward penetration of mucosal folds in these two cases. The metaplasia that subsequently followed may or may not have been the result of chronic inflammation.

Bacterial Endocarditis After Transurethral Prostatic Resection.—Acute or subacute bacterial endocarditis occurred eight times after 7,000 transurethral prostatic resections at the Mayo Clinic in the five years 1944 to 1948, inclusive. Thus the incidence of bacterial endocarditis was about one case in 1,000 transurethral prostatic resections. A total of 70 patients who underwent this operation during this period were found to have valvular heart disease. In seven (10 per cent) of these, bacterial endocarditis developed. Streptococcus faecalis or Micrococcus pyogenes (Staphylococcus aureus) was the pathogenic organism in all cases of bacterial endocarditis. It would seem logical to administer aureomycin prophylactically before and after transurethral prostatic resection to all patients with valvular heart disease.

Kansas Medical Society Journal, Topeka

52:1-44 (Jan.) 1951

Use of ACTH in Glomerular Nephritis. A. D. Mitchell and W. L. Valk.—p. 1.
Intestinal Obstruction: Report of Two Unusual Cases. H. S. O'Donnell and R. E. Bula.—p. 5.
Problems in Treatment of Juvenile Delinquency at Kansas Boys Industrial School. R. W. Coltharp and G. H. Weber.—p. 7.

Michigan State Medical Society Journal, Lansing

50:1-104 (Jan.) 1951

Observations on Intravenous Use of Pitocin in Obstetrics. L. F. Burnett and S. A. Cosgrove.—p. 33.
Overcoming Hemorrhagic Puerperal Mortality. S. A. Cosgrove.—p. 37.
Effect of Pregnancy on Urinary Tract. G. C. Prather.—p. 41.
Pain Relief During Labor. N. F. Miller.—p. 45.
Present Status of Problem of Syphilis. L. A. Brunsting.—p. 48.
Treatment of Eczematous Dermatoses: Topical Use of Antihistamine Agent Combined with Chloroiodchydroxyquinoline. A. S. Friedlaender and S. Friedlaender.—p. 54.
Angiocardiography in Differential Diagnosis of Mediastinal Pseudo-Tumor. M. W. Mattes and D. I. Fagin.—p. 57.
Rectal Administration of Dicumarol in Case of Mesenteric Venous Thrombosis. H. S. Seltzer.—p. 59.
Dilaudid Suppositories for Suppression of Cough Reflex: With Review of Medication by Rectal Administration in Childhood Diseases. K. Donelson.—p. 61.
Rational Approach to Benign Prostatic Hypertrophy. W. J. Butler.—p. 62.

New England Journal of Medicine, Boston

244:117-160 (Jan. 25) 1951

*Treatment of Acquired Hemolytic Anemia with Adrenocorticotrophic Hormone (ACTH). W. Dameshek, M. C. Rosenthal and L. I. Schwartz.—p. 117.
Acute Surgical Emergencies of Abdomen in Pregnancy. E. Hamlin Jr., M. K. Bartlett and J. A. Smith.—p. 128.
Antihistaminic Drugs in Treatment of Common Cold: Study Conducted at Boston University. F. C. Lowell, I. W. Schiller, J. E. Alman and C. F. Mountain.—p. 132.
Need for Psychiatry in Municipal General Hospital. M. Moore.—p. 135.
Medicine as Science: Pharmacology. W. T. Salter.—p. 136.

ACTH in Acquired Hemolytic Anemia.—A preliminary report is presented on the treatment of five patients with acquired hemolytic anemia with pituitary adrenocorticotropic hormone (ACTH). Three patients had hemolytic anemia of the "symptomatic" variety, being associated with lymphosarcoma or lymphocytic leukemia, and the other two had idiopathic hemolytic anemia. All the patients had circulating hemagglutinins and positive results from the Coombs test. There was intensive treatment with pituitary adrenocorticotropic hormone in doses of 60 mg. per day in three or four divided doses followed by maintenance treatment (20 to 30 mg. per day) in all cases but one. Four of the five patients had almost complete remissions of the hemo-

lytic process. Simultaneously there was disappearance of warm hemagglutinins and pronounced diminution of cold hemagglutinins. Results of the Coombs test first remained positive in all instances, but later became negative in three. One patient showed a tendency to excessive fluid retention that necessitated a lower daily dose of the hormone than that used in the other patients. The only other complication that could be attributed to the drug was the development of a mild psychosis in one patient. Relapses in the hemolytic process occurred shortly after discontinuation of treatment in two patients, and resumption of therapy resulted in a second remission. It is suggested that the favorable effect exerted by pituitary adrenocorticotropic hormone on this type of hemolysis is dependent on a disruption of agglutinin production, presumably by regression of lymphoid tissue, in which agglutinin may be produced. The stimulating effect of pituitary adrenocorticotropic hormone on bone marrow activity may result in a further beneficial effect. Three additional patients with acquired hemolytic anemia of idiopathic type were treated, and all showed dramatic responses. In these recent cases cortisone in tablet form was useful for maintenance therapy.

Proc. Soc. Exper. Biol. & Med., Utica, N. Y.

75:627-878 (Dec.) 1950. **Partial Index**

Presence of Myelokentric and Lymphokentric Acid in Sera of Patients with Lymphomatoid Diseases. C. G. Foster and F. R. Miller.—p. 633.
Variations in Serum Cholesterol of Normal Rabbits after Injection of Hypercholesterolemic Rabbit Plasma. E. Oppenheim and M. Bruger.—p. 636.
Effect of Aureomycin, Chloramphenicol and Para-Aminobenzoic Acid on Myxoma and Vaccinia Viruses in Egg. C. T. Lee.—p. 649.
Influence of Estradiol on P^{32} Uptake by Uterus. R. C. Grauer, H. S. Strickler, J. J. Wolken and E. Cutuly.—p. 651.
Similarity of Hematologic Effect of Pyridoxine Deficiency, Cortisone, and Myeloid Metaplasia Factor of Human Urine. D. R. Weir and R. W. Heinle.—p. 655.
Cerebrosides from Spleen and Brain from Adult with Gaucher's Disease. N. Halliday.—p. 659.
Production of Hypertension Following Choline Deficiency in Weanling Rats. C. Moses, G. M. Longabaugh and R. S. George.—p. 660.
Leukocytic and Pyrogenic Effects of Typhoid Vaccine and Augmentation by Homologous Plasma. R. S. Farr and V. S. LeQuire.—p. 661.
Studies of Newcastle Disease Virus (NDV) Propagated in Cave Bat (Myotus Lucifugus). R. L. Reagan, E. J. Smith and A. L. Bureckner.—p. 691.
Adsorption of Protective Antigen of Hemophilus Pertussis on Human Red Cell Stromata. L. Pillemer.—p. 704.
Effects of Vitamin B_{12} in Multiple Sclerosis. G. Simson, A. Herfort, M. Krim and L. M. Meyer.—p. 721.
Anemia Associated with Blind Intestinal Segments and Its Prevention with Aureomycin. R. W. Toon and O. H. Wangensteen.—p. 762.
*Hemorrhagic Diathesis with Ascorbic Acid Deficiency During Administration of Anterior Pituitary Corticotropic Hormone (ACTH). M. Stefanini and M. C. Rosenthal.—p. 806.
*Comparative Utilization of Fructose and Glucose Given Intravenously. T. F. Weichselbaum, R. Elman and R. H. Lund.—p. 816.
*Enhancing Effect of Cortisone upon Poliomyelitis Infection (Strain MEF1) in Hamsters and Mice. G. Shwartzman.—p. 835.

Hemorrhagic Diathesis During Treatment with ACTH.—Two patients are discussed who developed hemorrhagic manifestation presumably due to ascorbic acid deficiency while receiving high doses of pituitary adrenocorticotropic hormone (ACTH). Reports on the effect of pituitary adrenocorticotropic hormone on the metabolism of ascorbic acid in man are contradictory. Whereas some observers report no significant changes in urinary ascorbic acid excretion in patients treated with this hormone, others note increased excretion. The authors feel that in the two cases reported here the diagnosis of ascorbic acid deficiency was justified for the following reasons: (1) the occurrence of hemorrhagic manifestations in patients with only moderate abnormalities of other factors of hemostasis, (2) the low plasma ascorbic acid level and the low urinary excretion of the vitamin in these two patients, (3) the low plasma ascorbic acid tolerance curve (in the one case studied) and limited urinary excretion of ascorbic acid following the administration of 1 Gm. of the vitamin intravenously and (4) the regression after the administration of ascorbic acid of the typical hemorrhagic manifestations induced by trivial trauma of the skin. Ascorbic acid deficiency is probably not a common occurrence in the course of pituitary adrenocorticotropic hormone therapy but should be considered if hemorrhagic manifestations appear during prolonged administration of the hormone, when other factors of hemostasis are above critical levels.

Comparative Utilization of Fructose and Glucose.—Fructose, despite its slower rate of intestinal absorption (in the rat) is converted to hepatic glycogen more rapidly than dextrose. In vitro experiments using rat liver slices and homogenates have shown that fructose phosphorylation occurred 10 times more readily than dextrose phosphorylation. Invert sugar, which contains approximately 50 per cent fructose and 50 per cent dextrose, when injected into humans has been shown to produce less glycosuria than dextrose. These differences suggest that fructose might be a better sugar for intravenous administration than dextrose. In each of 10 human subjects two comparative experiments were carried out. The control consisted of the intravenous infusion of 1 liter of 10 per cent dextrose. Previously or subsequently, 1 liter of 10 per cent fructose was injected at the same or a faster rate. Even at rapid rates of infusion very little fructose appeared in the urine as compared to the amount of dextrose. Diuresis was also less pronounced with fructose. Moreover, the fructose infusions were not followed by either hyperglycemia or by an excessive rise in the blood fructose level, thus indicating a more rapid ultilization of fructose and presumably more rapid glycogenesis. Fructose is a much better sugar for intravenous feeding than dextrose.

Enhancing Effect of Cortisone on Poliomyelitis.—Studies on the effect of pituitary adrenocorticotropic hormone and cortisone on experimental poliomyelitis infection were carried out by the author because of the following observations: increased blood and tissue infections by Streptococcus hemolyticus occur in rabbits following injection of cortisone; bacteremia appeared during crisis in a case of pneumonia treated with pituitary adrenocorticotropic hormone, and pregnant women, in whom there is a greatly enhanced adrenocortical function, show an increased incidence of poliomyelitis. The author found that pituitary adrenocorticotropic hormone and cortisone in combination or cortisone alone cause decided acceleration of poliomyelitis infection in mice and an extraordinary enhancement of susceptibility to this infection in hamsters, giving rise to a violent and uniformly fatal disease. Pituitary adrenocorticotropic hormone alone fails to produce this effect, possibly owing to elaboration of an unknown factor capable of reversing the enhancing effect of cortisone. The experiments seem to indicate the existence of a significant relation between adrenocortical function and susceptibility of mice and hamsters to experimental poliomyelitis.

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South Carolina Medical Assn. Journal, Florence.

47:1-44 (Jan.) 1951

*Bilateral Polycystic Ovaries (Large White Ovaries). G. T. McCutchen and E. C. Kinder.—p. 1.
Cardiovascular Heart Disease. J. F. Rainey.—p. 8.
*Congenital Hypertrophic Pyloric Stenosis. A Review of 329 Cases. R. P. Baker.—p. 10.
Clinical Significance of Foreign Body Granulomas: a Review. D. Symmers.—p. 14.
Cancer. Carcinoma of the Skin. R. W. Postlethwait.—p. 21.

Bilateral Polycystic Ovaries.—McCutchen and Kinder report 19 women, 18 with proved bilateral polycystic ovaries and one in whom the syndrome was suspected. Thirteen of the patients were married, and six were single. Amenorrhea and sterility were the outstanding features. Less frequently observed were hirsutism, headaches, obesity and hypodevelopment of the breasts. The pathological counterpart of the ovarian disturbance consisted of bilaterally, symmetrically enlarged, pearly white gonads with marked condensation of the tunica. A preoperative diagnosis of the syndrome was made in nine of the author's patients. Two additional cases were suspected. Of the remaining undiagnosed cases two were operated on for appendicitis, four for ovarian cyst and one patient underwent an exploratory operation because of sterility and uterine fibromyoma. Five of these cases showed only polycystic ovaries, while three were complicated by other pathology. Sterility was an expressed concern in nine of the patients. Three of these patients subsequently conceived and delivered normal babies. Sufficient time has not elapsed since surgery to draw conclusions regarding correction of sterility. Hormone therapy was extensively used in nine of the patients without benefit. Partial failure in correction of the syndrome in two of the 18 patients resulted from overcautiousness in resect-

ing of ovaries that were unusually large. The syndrome of bilateral polycystic ovaries is readily corrected in the majority of cases by surgical attack on the gonads. Bilateral wedge resection with suture is the most satisfactory procedure. The authors' cases were collected during the past four years, indicating that the condition, though not common, is certainly not rare. The syndrome represents one of the few entities that justify surgical attack on the ovaries. The operative procedure is simple; the results are gratifying.

Congenital Hypertrophic Pyloric Stenosis.—Baker reports 265 male and 64 female infants on whom a Fredet-Ramstedt pyloroplasty was performed for congenital hypertrophic pyloric stenosis. There is a definite tendency for the anomaly to occur in firstborn children; the incidence of first births numbered 171 (64.5 per cent). There was also a slight tendency for familial occurrence. A genetic basis may be considered, but as yet the method of inheritance is undetermined, and an evironmental factor may play a significant role in its production. The onset of symptoms occurred most frequently between the second and third weeks; 87 (27.1 per cent) infants had vomiting at the age of 2 weeks and 81 (25.2 per cent) at the age of 3 weeks. Eighty (24 per cent) underwent pyloroplasty during the fourth week of life, while others underwent operation for pyloric stenosis during each week from the third to the twenty-fourth week of life. Barium x-ray studies of the stomach are not necessary in the presence of the five cardinal signs, namely, projectile vomiting, scanty stools, loss of weight and dehydration, visible peristalsis and a palpable tumor. Roentgen studies are essential if the symptoms begin shortly after birth, to establish the presence or absence of duodenal atresia. Surgical treatment should be resorted to immediately after adequate preoperative preparation in those cases that do not respond to medical measures promptly. A tumor was observed at operation in each of the patients. It was described as large in 93 per cent and small to moderate in 7 per cent. The chief risk of the operative procedure is the perforation of the duodenum at the point where the thick pyloric muscle ends. The duodenum was opened in 23 patients; only one of them died. None developed evidence of peritonitis. There was a surgical mortality of 3.9 per cent following the pyloroplasty. The chief causes of death were pulmonary atelectasis, peritonitis, gastroenteritis and bronchopneumonia. Brevity of hospitalization after surgery is one of the chief arguments in favor of this type of therapy. In the series reported on, the average total number of days spent in the hospital was 17.

U. S. Armed Forces Med. J., Washington, D. C.

2:1-170 (Jan.) 1951. **Partial Index**

Neurotic Potential, Neurotic Process, and Neurotic State. L. S. Kubie.—p. 1.
Significance of Heart Murmurs in Induction Examinations. R. P. Johnson.—p. 13.
Ballistocardiograph in Clinical Medicine. H. A. Lyons.—p. 25.
*Long-Acting Heparin Preparation: Useful Adjunct in Anticoagulant Therapy. Clinical Trial of Depo-Heparin Sodium in 15 Cases. W. J. Smiles.—p. 45.
*Arterial Blood Culture. M. B. Sullivan Jr. and C. P. Powell.—p. 63.
Dynamics of Lumbar Puncture. G. T. Wannamaker.—p. 67.
Myocardial Infarction in Young Adults. M. R. Baker and W. R. Schillhammer Jr.—p. 75.
Pancytopenia Following Use of Mesantoin and Thiantoin: Report of Fatal Case. H. A. Weiss and W. D. Hawley.—p. 83.
Hypogonadism: Puberal Seminiferous Tubule Atrophy. R. Lawrence and R. A. Kallsen.—p. 87.
Study of 500 Autopsies in Cases of Tuberculosis. M. C. Davenport and H. M. Greenleaf.—p. 97.
Abdominal Hysteropexy for Uterine Prolapse. P. Peterson and S. L. Arje.—p. 113.
Application of Civil Defense Lessons Learned in World War II. W. L. Wilson.—p. 119.

Long-Acting Heparin Preparation.—Depo®-heparin sodium was tested as an anticoagulant and as an adjunct to bishydroxycoumarin (dicumarol®) in 15 patients with thromboembolic disease. Nine were patients with coronary artery disease suspected of having myocardial infarctions, five had acute thrombophlebitis of the leg veins and one had extensive deep thrombophlebitis. The coagulation time was determined by the modified Lee-White method, giving a normal average end point between five and 15 minutes. For the average patient, this determination should be made once a day near the end of the 24 hour period following injection. Administration of depo®-heparin without vasoconstrictors in doses of 300 to 400 mg. initially and 200 to 300 mg. given 23 to 24 hours later on successive days increased the normal coagulation time two to four times. A single injection of this dose will give this lengthened coagulation time for about 24 hours. No complications were observed either in control or in management while depo®-heparin and bishydroxycoumarin were being combined, and the change was accomplished with ease. The prothrombin time was not appreciably changed by depo®-heparin during the first 24 hours, when it was used alone. No significant discomfort follows the use of depo®-heparin provided it is injected at body temperature into the deep subcutaneous tissues. This method of injection is superior to intramuscular injection. For optimal results, the patient should be cautioned not to apply pressure at the site of injection. Depo®-heparin sodium is to be considered a satisfactory adjunct to bishydroxycoumarin.

Arterial Blood Culture.—Sullivan and Powell report a case with clinical findings suggestive of subacute bacterial endocarditis in which therapy with penicillin and carinamide had failed. The arterial blood culture was positive for Streptococcus viridans although the venous blood culture was not. Sensitivity studies demonstrated the need for 12,000,000 units of penicillin daily. An apparent cure was effected without any evidence of a remission nine months later. The radial artery is easily located and punctured without excessive pain. If this artery is not easily palpable, the femoral artery is a satisfactory substitute. The need for early determination of the specific infecting organism and its sensitivity to antibiotics has become important with the development of a variety of new antibacterial agents. It is suggested that arterial blood culture is a quicker and more accurate method of obtaining this information than is venous blood culture.

West Virginia Medical Journal, Charleston

47:1-38 (Jan.) 1951

The Silicosis Problem. B. Gordon.—p. 1.
West Virginia's First Camp for Diabetic Children (Report on Camp Kno-Koma). G. P. Heffner and A. P. Miller.—p. 9.
Method of Allergic Investigation. F. C. Reel.—p. 12.
Mesonephroma. C. B. Wright.—p. 15.
*Neonatal Glomerulonephritis. A. C. Thompson.—p. 16.

47:39-68 (Feb.) 1951

Management of Gastro-Intestinal Hemorrhage. J. O. Burke.—p. 39.
Resistant Club Feet. A. F. Coshell.—p. 44.
Present Problems and Concerns in Practice of Anesthesiology. A. W. Friend.—p. 49.
Newer Insulins and Some of Complications of Insulin Administration. H. B. Mulholland, F. V. Vance Jr. and T. S. Edwards.—p. 53.

Neonatal Glomerulonephritis.—The case reported by Thompson was one of subacute to chronic glomerulonephritis in a newborn infant, who died at 29 days. The diagnosis was not suspected until microscopic sections of the kidneys were studied. Consequently, no blood chemistry determinations were done. The microscopic aspects indicate diffuse glomerulonephritis of rather long duration, which by comparison with the findings in adults, would probably be more than four weeks. The muscular hypertrophy and periarterial fibrosis probably indicate that the hypertension has been present for some time. This, as well as the location of the most marked arterial changes in the myocardium of the right ventricle, points to onset of the disease during fetal life. The calcification in the liver septums was probably caused by uremic retention in connection with prolonged vomiting and dehydration. It is therefore unlikely that this disease was extrauterine in origin. The child's father was homozygous (Rh$_1$) positive, the mother, Rh negative; but erythroblastosis was ruled out, because there were no blocking antibodies, no circulating normoblasts in the baby's blood smear, no anemia and no jaundice. The fact that the mother had pharyngitis during her sixth month of pregnancy is regarded as possibly significant. It is also pointed out the pregnancy preceding the one discussed here resulted in the birth of a child who also died at the age of one month after progressive edema and periods of cyanosis. The literature reveals few cases of true neonatal glomerulonephritis. Its familial occurrence cannot be denied. The mortality is high. The mechanism of pathogenesis may be intrauterine sensitization to organisms in the mother.

FOREIGN

British Journal of Dermatology and Syphilis, London

62:485-544 (Dec.) 1950

Familial Primary Self-Healing Squamous Epithelioma of Skin. J. Sommerville and J. A. Milne.—p. 485.
Treatment of Acne with Sulphur Lotion. N. M. Wrong.—p. 491.
Dermatomyositis: Report of Case. R. B. Pilcher.—p. 494.

British Journal of Urology, London

22:265-460 (Dec.) 1950. Partial Index

Renal Nerves. G. A. G. Mitchell.—p. 269.
Preliminary Report on Abdominal Aortography in Urology. I. H. Griffiths.—p. 281.
Hydrocalicosis. T. Moore.—p. 304.
Tumours of Vesical End of Ureter. F. Masina.—p. 320.
Results of Diathermy Treatment of Villous Papilloma of Bladder. H. Donovan.—p. 332.
Vesical Tumours: Analysis of Personal Series. D. Band.—p. 381.
*Squamous Metaplasia of Prostate Gland. E. M. Nanson.—p. 394.
Pull-Through Operation for Impassable Traumatic Stricture of Urethra. A. W. Badenoch.—p. 404.
Immediate Prostatectomy by Millin's Method for Acute Retention of Urine. B. B. Hickey.—p. 410.
Treatment of Carcinoma of Bladder. D. S. Poole-Wilson.—p. 414.
Treatment of Cancer of Bladder. J. M. W. Gibson.—p. 424.
Results of Treatment of Bladder Cancer by Radiotherapy. J. L. E. Millen.—p. 430.

Squamous Metaplasia of Prostate.—Nanson feels that the occurrence of squamous metaplasia of the prostate cannot be as infrequent as the paucity of reports seems to indicate, because at his hospital six cases were observed in three months. These six cases and another one observed in 1947 are described in this report. Reviewing the literature on squamous metaplasia of the prostate the author mentions Lacassagne's report of 1933, which revealed that when an estrin was given to mice over a period of three months, in 14 out of 16 animals squamous metaplasia of the prostate gland developed, and the gland hypertrophied to such a degree that it produced serious obstruction at the bladder neck, with consequent upper tract dilatation, renal failure and death. This and similar reports indicate that squamous metaplasia develops in the prostate gland of mice, dogs and monkeys as a result of estrin therapy. The first four patients recorded in this paper had extensive squamous metaplasia of the prostate gland unassociated with infarction, and all four had had diethylstilbestrol therapy. Cases 5 and 6 described here show that squamous metaplasia developed at the periphery of infarcts. It also developed in a gland with chronic inflammation (case 7).

British Medical Journal, London

1:151-204 (Jan. 27) 1951

Vitamin B_{12} Group of Factors. E. L. Smith.—p. 151.
Effect of Vitamin B_{12}c in Pernicious Anaemia and Subacute Combined Degeneration of Cord. C. C. Ungley.—p. 152.
Vitamin B_{12} and Folic Acid in Megaloblastic Anaemia After Total Gastrectomy. N. C. Conway and H. Conway.—p. 158.
Haemopoietic Activity of Vitamin B_{12}c and B_{12}d in Pernicious Anaemia. J. N. M. Chalmers.—p. 161.
Two Cases of Pernicious Anaemia Treated with Vitamin B_{12}d. G. C. K. Reid.—p. 164.
Mucus Catheters. M. S. Fraser.—p. 165.
Chronic Renal Disease with Secondary Hyperparathyroidism. D. G. B. Richards.—p. 167.
Cryoglobulinaemia in Multiple Myelomatosis. A. N. Blades.—p. 169.

Edinburgh Medical Journal

57:497-560 (Nov.) 1950

*Heredity and Germ Cell Continuity. A. N. Bruce.—p. 497.
Extra-Dural Cyst—Ganglion Neuroma. D. E. C. Mekie and G. Ransome.—p. 515.
Observations on Cirrhosis of Liver. D. M. F. Batty.—p. 522.
Labour Saving Methods in Cell Counts. B. Woolf.—p. 536.
Streptomycin Resistance in Tubercle Bacillus. J. A. F. McLean.—p. 547.

Heredity and Germ Cell Continuity.—The author discusses the possibility of germ cells arising from somatic cells. The first product of the cleavage of the fertilized egg is a larval form, or asexual generation, which is formed by a process of apical growth. The sudden change from apical to bilateral growth denotes the appearance of the primitive germ cell and the development of the sexual generation. The primitive germ cell gives rise to a specific number of primary germ cells, one of which develops into an embryo, into which the remaining germ cells migrate. As the primary germ cells are all in existence before the development of the embryo, they cannot arise from it and are thus not somatic in origin. The embryo itself consists solely of somatic cells. Its purpose is to provide a temporary home for the germ cells during a particular phase of their life cycle. The germ cells are derived from a previous generation of germ cells and will give rise to a new generation of germ cells. They are unicellular organisms and are endowed with immortality. The primary germ cells are identical with each other, and with the one that has formed the embryo. Any one of the primary germ cells is capable of forming an embryo, but what determines the choice of a particular germ cell is unknown. If, however, it should happen that two germ cells develop embryos, identical twins will result. If an abortive embryo is formed, then the pathological growth known as an embryoma or teratoma will be found. That these should be most frequently found in the ovary and testis is easily explained as these are the organs where the majority of the germ cells are situated. A close relationship exists between pathological germ cell growth and certain types of tumor formation. Persistence of the larval formation may also lead to malignancy.

Lancet, London

1:123-180 (Jan. 20) 1951

Proper Use of Hospital in Treatment of the Aged Sick. Lord Amulree, A. N. Exton-Smith and G. S. Crockett.—p. 123.
Mortality from Circulatory Diseases in Norway 1940-1945. A. Strøm and R. A. Jensen.—p. 126.
*Laterally Placed Cervical Discs: Review of 12 Cases. M. Jefferson.—p. 129.
Function of Erectores Spinae in Flexion of Trunk. W. F. Floyd and P. H. S. Silver.—p. 133.
*Thiouracil Compounds in Prevention of Paroxysmal Cardiac Arrhythmia. H. D. Ruskin.—p. 134.
Trial of Beta-Naphthyl-DI-2-Chloroethylamine in Leukemia, Hodgkin's Disease, and Allied Disorders. C. Gardikas and J. F. Wilkinson.—p. 137.
Acrosclerosis. T. R. Littler and S. Canter.—p. 139.
Effect of Implantation of Tablets of Insulin on Normal and Alloxan-Diabetic Rabbits. I. C. Gilliland and M. M. Martin.—p. 143.
Liver Fluke Removed from Human Common Bile-Duct. J. S. Ramage.—p. 146.
Subacute Bacterial Endocarditis Caused by Coagulase-Negative Staphylococcus Albus. H. Matthew.—p. 146.
Acute Infectious Lymphocytosis in Adult. B. Malamos and A. Stamatelakis.—p. 148.
The "Duffy" Antibody and Haemophilia. J. D. James and G. Plaut.—p. 150.
Simple and Reliable Test for Bile-Pigments in Urine. J. Ingham.—p. 151.

Laterally Placed Cervical Disks.—When disorders due to herniations of intervertebral disks were originally recognized it was thought that the symptoms were due to compression of the spinal cord rather than the nerve roots. Since then, however, many workers have described isolated root injury due to laterally placed cervical disk herniations. There is now plentiful evidence that lateral rupture is in fact commoner than central protrusion and that brachial neuralgia of radicular type is more often encountered than the syndromes of spinal cord compression. This survey is based on the study of 12 patients who had cervical nerve root disturbances due to ruptured disk. The diagnosis was proved at operation in four cases, confirmed myelographically in two others and made on clinical grounds alone in the remaining six. The average duration of symptoms was eight months. In only one patient was there a history of frank injury to the neck. Pain was unilateral in 11 cases; in one case it was bilateral but severer on the left side. Conservative measures were adopted in most cases. Immobilization of the neck by a plaster collar for six to eight weeks was usual. In all cases so treated, pain and other symptoms were rapidly relieved. Cure was permanent on removal of the cast, except in one patient. Four patients had surgical therapy. Three made excellent recoveries; the fourth had postoperative signs of damage to the spinal cord. Although her brachial neuralgia has been completely relieved and the signs of damage to the cord have somewhat regressed, she still has, a year after operation, a fairly

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An asterisk (*) before a title indicates that the article is abstracted. Single case reports and trials of new drugs are usually omitted.

pronounced disability. Several illustrative case histories are presented. The levels of disk protrusion are discussed, the symptoms and signs of involvement of various radicles are considered and the usefulness of radiological findings assessed. Conservative treatment, in the form of plaster immobilization of the neck, is recommended as the most desirable.

Thiouracil Compounds in Cardiac Arrhythmia.—Quinidine or digitalis are generally used for cardiac arrhythmia, but problems of dosage and toxicity arise. Because thiouracil compounds are effective in the control of angina pectoris, and because the factors precipitating attacks of angina and paroxysmal cardiac arrhythmias are mainly identical, it was thought that these drugs might be valuable in preventing arrhythmia. Ruskin administered thiouracil derivatives to seven patients, in all of whom previous treatment with quinidine and digitalis had been unsatisfactory. In four of the patients the attacks occurred daily; in two, several attacks occurred each week, and, in one, several each month. Two of the patients had apparently normal hearts, three had hypertensive heart disease and two had rheumatic valvular disease. Electrocardiographic proof of the arrhythmia was obtained in six cases; three had supraventricular tachycardia, two auricular fibrillation, with auriculoventricular block, and two auricular fibrillation. In one patient with frequent severe attacks of auricular flutter not responding to quinidine alone the administration of methylthiouracil—0.6 Gm. daily in three divided doses—in addition to 6 grains (0.40 Gm.) of quinidine at four-hour intervals produced almost complete freedom from attacks for three months. Later, while taking methylthiouracil alone, she continued to have mild attacks, which were terminated by quinidine given intravenously. When propylthiouracil was substituted for the methyl preparation, attacks became infrequent and less severe, and the patient was able to lead a comparatively normal life. The remaining six patients were not hospitalized but received out-patient treatment. In four of the seven patients the paroxysms were completely prevented; in two they became less frequent and less severe, and in one there was no response. In two patients the combination of a thiouracil compound with quinidine was more effective than either drug alone.

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1:181-244 (Jan. 27) 1951

Acute Obstructive Laryngotracheitis and Laryngotracheobronchitis: Report of Outbreak. J. O. Forfar, K. R. Keay and J. Thomson.—p. 181.
Orthopaedic Signs in Diagnosis of Disc Protrusion with Special Reference to Straight-Leg-Raising Test. J. Charnley.—p. 186.
Seasonal Incidence of Congenital Malformations of Central Nervous System. T. McKeown and R. G. Record.—p. 192.
Infection of Digital Pulp Space. T. G. Lowden.—p. 196.
Aetiology of Chronic Gastric Ulcer: Observations on Blood-Supply of Human Gastric Mucosa with Note on Arteriovenous Shunt. F. S. A. Doran.—p. 199.
Electrophoretic Serum-Protein Pattern in Malignant Malnutrition. C. G. Anderson and A. Altmann.—p. 203.
Uniovular Twins Showing Growth Disparity Due to Renal Dwarfism. M. D. Milne.—p. 204.
Investigation of Sugar Tolerance. J. Friend.—p. 207.
*Duodenal Intubation with Magnet-Tipped Tubes. A. H. James.—p. 209.
*Procaine with Hyaluronidase as Local Anaesthetic. J. N. Thorpe.—p. 210.
*Congenital Afibrinogenaemia. A. I. D. Prentice.—p. 211.
Poliomyelitis and Polioencephalitis with Opsoclonia Following Appendicectomy. M. D. Warren.—p. 213.

Duodenal Intubation.—Intubation of the duodenum is often difficult without the use of fluoroscopy, and there are many situations in which fluoroscopy is impractical, particularly when the patient is a small child or is seriously ill. To obviate this difficulty the author has developed a method of locating the tube tip without the aid of x-rays. He incorporates a small permanent magnet into the tip of the tube and then follows its progress through the stomach by pressing a small compass on the abdomen and noting the deflections of the needle. Not only the location but the direction of the tube tip can be determined by this method. The practical value of the method was demonstrated in 17 adults. When the tube was thought to have entered the duodenum as judged by the compass, a roentgenogram was taken. In 14 patients (82.5 per cent) the tube was actually in the duodenum, and in three it was in the pyloric antrum. Similarly, in 20 out of 21 children the duodenum was reached rapidly by this technique. It was hoped that the magnet-tipped tube might also be controlled from the outside by a large electromagnet, but this did not prove to be practical.

Hyaluronidase in Local Anesthesia.—Hyaluronidase has been found useful in promoting diffusion of local anesthetics through the tissues surrounding a fracture site. Under ordinary circumstances local infiltration anesthesia for the reduction of fractures is unsatisfactory because of the slow and incomplete diffusion of the anesthetic solution with resultant slow and incomplete analgesia. When hyaluronidase is mixed with procaine (1,000 "Benger units" of hyaluronidase to 20 cc. of 1 per cent procaine) the anesthetic diffuses rapidly through the entire injured area, and the fracture can be manipulated painlessly as soon as the needle is withdrawn. The fracture area remains pain free for over an hour. Thorpe has used this technique successfully in 22 cases of Colle's fracture and in four cases of Pott's fracture. He states that it has many advantages over inhalation, intravenous or regional anesthesia. It is safer, more rapid and longer lasting. The patient is immediately ambulatory for x-ray check-up, and postanesthetic hospitalization is not required.

Congenital Afibrinogenemia.—One of the causes of hemorrhagic diathesis is congenital absence of fibrinogen. A case of this rare entity is reported in a 19 year old man who was admitted to the hospital because of headaches, fever, epistaxis and chest pain. He had a history of bleeding beginning with profuse hemorrhage from the cord at birth, and from minor injuries since that time. He had always bruised easily and had been told he had hemophilia. There was neither family history of bleeding nor consanguinity of parents. Roentgenograms of the joints showed none of the changes expected in a hemophiliac. The patient's bleeding time was six minutes and 30 seconds (Duke's method), but the clotting time by the capillary tube method showed no clot after two hours. No clot formed when whole blood was incubated at 37 C. for three days or when plasma was heated to 60 C., nor did quarter saturation of the plasma with ammonium sulfate precipitate any fibrin. When fibrinogen was added to the plasma and a Quick test performed, a clot did form, indicating the presence of some prothrombin. The platelet count and capillary fragility were normal. The erythrocyte sedimentation rate was only 5 mm. per hour. The patient was found to have tuberculous bronchopneumonia with pleural effusion, which eventually proved fatal. At autopsy no clots were found in any of the vessels or in the heart. The liver was enlarged and pale but microscopically showed little change except slight fatty degeneration and an occasional giant cell tubercle. Apparently, liver disease was not the cause of the afibrinogenemia, which remains unexplained.

Medical Journal of Australia, Sydney

2:881-916 (Dec. 16) 1950

Conditions of Civilized Living and Problems of Mental Health. O. A. Oeser.—p. 881.
Effects of Sodium Citrate in Lead Poisoning and Lead Absorption: Lead Poisoning. D. O. Shiels, W. C. Thomas and G. R. Palmer.—p. 886.
*Should We Treat Leucaemia in Childhood? J. H. Colebatch and A. L. Williams.—p. 892.
Management of Severe Burns in the "Tarakan" Explosion. K. W. Starr, P. Grant and F. Farrar.—p. 895.
Biochemical Observations on Casualties Burned in Petrol Explosion. H. S. H. Wardlaw.

Should Childhood Leukemia Be Treated?—Colebatch and Williams feel that the results obtained with the folic acid antagonists, particularly aminopterin (4-aminopteroylglutamic acid), justify a reconsideration of the question: Should leukemia in children be treated? The observations reported here were made on 26 leukemic children who had been referred to Colebatch since the middle of 1948. The leukemia was lymphatic in 20 cases, myeloid in three and monocytic in three. Of the 26 patients, 18 were treated with aminopterin and eight were controls. The patients were not selected on clinical grounds. Irradiation of the spleen was used in two relatively resistant cases of the aminopterin-treated series; urethane was used in one case of the control series. These agents did not appear to produce appreciable symptomatic relief or to prolong life. Six patients died within the first two weeks; three had been treated with aminopterin and three were controls. In view of the extreme toxicity of the folic acid antagonists, the authors feel that their use should be restricted to institutions in which experienced observers and the fullest hematological facilities are available.

Clinical remissions occurred in 13 of the 15 cases in the aminopterin series and in three of five cases in the control series. In three of the aminopterin-treated cases there was more than one remission, and in one of the control cases there were several partial remissions. Hematological improvement occurred in all cases, but was of greater degree and duration in the aminopterin series. The average period of survival was 21 weeks in the aminopterin series and 10.4 weeks in the control series. The authors conclude that the decision to treat or not to treat the leukemic child should be made by the parents after they have been fully acquainted with the facts.

Acta Medica Orientalia, Jerusalem

9:267-308 (Nov.-Dec.) 1950. **Partial Index**

Clinical Electroencephalography. M. Ostow.—p. 267.
Function of Seminal Vesicles in Humans. M. Michael.—p. 283.
*Case of Periarteritis Nodosa Treated with Benadryl and Penicillin. N. Schrager.—p. 293.
Infectious Diseases in Israel in September-November 1950. G. Kallner. —p. 299.

Periarteritis Nodosa Treated with Benadryl® and Penicillin.—The etiology of periarteritis nodosa is unknown, but many different causes have been considered. At present, infections, toxins, viruses and allergies are being discussed as possible causes. Periarteritis nodosa is usually fatal; although spontaneous recoveries have been reported, it has also been stressed that such recovery may occur only in cases where no vital organs have been attacked. In the case reported in this paper, the clinical diagnosis of arteritis nodosa was confirmed by biopsy. The onset was gradual, with involvement mainly of the skin and the articular system; the spleen, heart, liver, gastrointestinal tract, lungs and, finally, the kidneys were each at one time or another the focus of the disease. The involvement of the heart and kidney are discussed in detail. Because both infection and allergy seemed to play a part in the etiology of the disease in this patient, he was treated with diphenhydramine hydrochloride (benadryl®) as well as with penicillin. The fact that the patient recovered is not irrefutable proof of the efficiency of the treatment, but the combined diphenhydramine hydrochloride-penicillin treatment has been used by several other authors with good results.

Cardiologia, Basel

17:127-250 (No.3/4) 1950. **Partial Index**

Electrocardiographic and Kymographic Investigations in the Standing Position Before and After Treatment with Hydrogenated Alkaloids of Ergot with Consideration of Behavior of Leukocytes and Blood Sugar. U. Ströder.—p. 127.
Virus Myocarditis (Viral Action, Functions of the Host). E. Lyon. —p. 175.
*The Hypoxemia Test: An Analysis of 1,130 Tests. G. Nylin, V. de Fazio and F. Marsico.—p. 191.
Hypertrophy of Thymus which Simulates in Adolescents an Increase of the Cardiovascular Image. M. Sposito and V. Masini.—p. 210.

The Hypoxemia Test.—To evaluate the hypoxemia test as a means of diagnosing coronary artery disease, the authors performed 1,130 tests on 1,103 patients. Included in the series were persons with coronary and noncoronary heart disease and controls without heart disease. Excluded were patients with congestive heart failure, serious respiratory disease, severe anemia, poor general condition or advanced age. The subjects breathed a mixture of 9 per cent oxygen in nitrogen for 10 minutes, electrocardiograms being taken before and at the end of the test. Following this, pure oxygen was administered. The test was interrupted if pain or other symptoms appeared. The usual electrocardiographic leads were employed, and special importance was attached to changes in the ST segment. Significant changes in the electrocardiogram occurred in 30.88 per cent of the patients with angina pectoris and in 4.53 per cent of those in whom there was no suspicion of coronary artery disease. The latter group showed neurogenic or hormonal disturbances that might conceivably alter the electrocardiogram. The results were consistent in 23 of 32 tests that were repeated and variable in the others. No accidents were caused by the tests. The authors conclude that abnormal findings on the test do not always mean organic coronary insufficiency and that normal results do not rule out coronary artery disease. Nevertheless, they feel that the test can play a useful though limited role in establishing this diagnosis. If patients are selected carefully and the technique is followed closely, the risk involved in the test is negligible.

Fortschr. Röntgenstrahlen & Röntgenpraxis, Stuttgart

73:649-814 (Dec.) 1950. **Partial Index**

Roentgenologic Aspects of Pulmonary Changes Caused by Ocher. R. Haubrich.—p. 682.
Pulmonary Edema of Central Origin. V. Buchtala.—p. 702.
*Roentgenologic Changes in Pulmonary Tuberculosis Treated with a Cobalt Complex. W. Glauner.—p. 713.
Calcifications of Choroid Plexus of Lateral Ventricles as Sequel of Congenital Toxoplasmosis. K. Lorenz.—p. 735.
Angular Dorsolumbar Kyphosis as Skeletal Sign in Congenital Myxedema. W. Swoboda.—p. 740.
Giant Cell Fibroma. E. Morvay.—p. 754.

Roentgenologic Changes in Pulmonary Tuberculosis Treated with a Cobalt Complex.—Glauner has previously reported the use of a complex of the trace element cobalt in the treatment of pulmonary tuberculosis. In this report he is concerned chiefly with the pulmonary roentgenologic changes that developed during the course of such treatment. The cobalt complex was given intravenously. The clinical improvement produced by this treatment was reflected in the roentgen pictures. Frequently there was a rapid regression of new exudative foci or a progressive cicatrization. Cavities disappeared in seven of the 18 patients. In two other patients cavities decreased in size with cobalt therapy and there was also significant improvement in the clinical picture. The reduced cavities later yielded to pneumothorax therapy. The remaining nine cavities were rather rigid, but they too decreased in size. Ten patients who had no cavities all showed much improvement in the roentgen picture: their weight increased, the quantities of sputum decreased and the bacilli disappeared. The blood picture improved. The author believes that the cobalt complex might prove of value in the chemotherapy of pulmonary tuberculosis.

Journal de Médecine de Lyon

32:41-88 (Jan. 20) 1951. **Partial Index**

Histological Classification of Bronchopulmonary Tumors; Postoperative Courses Compared According to Histological Types; "Adenomas" and Benign and Malignant Polypoid Tumors. P. Santy, M. Bérard and P. Galy.—p. 41.
*Importance of Enzymatic and Allergic "Pericellular" Factors in Modifying Rhythm of Development of Epithelial Tumors. A. Morel and A. Josserand.—p. 51.
Three Elements Constituting the Inflammatory Factor in Course of Development of Epithelial Cancers: Conclusions Concerning Anti-Inflammatory Treatment of Cancer. A. Morel and A. Josserand.—p. 59.

Enzymatic and Allergic "Pericellular" Factors in Development of Epithelial Tumors.—Experiments in vitro and in vivo conducted by Morel and Josserand demonstrated an inflammatory noninfectious component in the development of many cancers. Frequently, an inflamed, edematous zone was observed surrounding the tumor, particularly in buccopharyngeal tumors and in carcinoma of the breast. This inflammatory process was accompanied frequently by the sudden appearance of inflamed lymph nodes, although microscopic examination did not reveal any bacterial invasion. These manifestations may appear rapidly within a few hours, reminding one of the edema and adenopathy occurring in the course of serum disease. The pseudoinfectious inflammation and perifocal edema are related to autolysis of tumor cells, which is accompanied more or less by lysis of the adjacent normal tissues. Cell lysis itself is induced by the ferments of the tumors. The organism reacts to these lysates in an allergic way, which explains the sudden appearance of the edema and the adenopathy. Pseudoinfectious inflammation and perifocal edema favor extension of cancer. When the edema recedes it leaves behind a local spread of the cancer. It facilitates metastasis by passively carrying the neoplastic cells through the dilated lymph channels. Periods of partial lysis alternate with periods of growth, and during the phase of equilibrium the lysates are absorbed by the organism in the absence of perifocal edema. The organic equilibrium lasts until an allergic reaction precipitates a flare-up. This it does by producing edema fluid rich in "embryonal trephones," which prevents the absorption of the autolysate and constitutes a favorable medium for the germination of cells. The edematous infiltrations are responsible

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for pain associated with cancer because they compress delicate nerve branches. Reduction of congestion at the periphery of the tumors provides immediate relief from pain. The slow course of certain cancers with pronounced stroma reaction, such as mammary epithelioma, is due to the absence of strong enzymatic reactions and of perifocal edema rather than to the stroma reaction that thus was given time to develop.

Nederlandsch Tijdschrift v. Geneeskunde, Amsterdam

94:3521-3616 (Dec. 9) 1950. **Partial Index**

*Diagnosis on Basis of First Symptoms of Leprosy. W. de Broekert. —p. 3528.
Amebiasis: Diagnostic and Therapeutic Experiences in 225 Patients. M. Plooij and P. Wüstefeld.—p. 3532.

First Symptoms of Leprosy.—Since the return of Dutch soldiers from Indonesia may increase the incidence of leprosy in the Netherlands, the Dutch general practitioner should become acquainted with the first symptoms of leprosy. Typical prodromal signs are rare. In a minority the anamnesis may reveal complaints of a stopped-up nose or paresthesias. In the most favorable form, that is, the tuberculoid form, of leprosy the first sign is usually a flat "patch," or a localized area of anesthesia or both. Patches can be depigmented and flat or depigmented with mildly erythematous and infiltrated edges, or completely erythematous and infiltrated. They usually appear on the face, extremities, nates and scapulas and are sharply defined from the surrounding tissue. Such patches should be tested for their reactions to pain, temperature and touch; patches on the face usually show no changes for a long time, those on the body first show decrease in temperature perception, while those on the extremities show disturbances in all sensations. Nerves are then palpated, because they often show swelling in the region of the spots; the ulnar and the auricularis magnus are the nerves most frequently involved. Similar spots may occur in fungus diseases, but these can generally be differentiated by the slight desquamation and the absence of sensory disturbances. Another characteristic of the leprosy patches is that the hair falls out in these regions and that perspiration is abolished. While the lepromatous form of leprosy may begin with tuberculoid patches, usually the lesions in this form are erythematous and may simulate urticaria, except that they do not itch and do not rapidly disappear as in urticaria. They are not as localized as in the tuberculoid form but are more diffuse over the entire body and are usually not sharply defined from the surrounding tissue. Nodules, bullae and swelling of the nerves usually appear later. The lepromatous lesions usually do not show sensory disturbances during the early stages, and the diagnosis must then depend on the demonstration of bacilli. The author describes a method that facilitates the demonstration of bacilli.

Presse Médicale, Paris

59:1-20 (Jan. 6) 1951

Excessive Hepatic Insufficiencies. E. Chabrol.—p. 1.
Value of Vaginal Smears for the Detection of Cancer of Uterus. A. Netter, H. Yaneva, A. Lambert and P. Laulanie.—p. 2.
*Chloramphenicol (Chloromycetin®) in Progressive Doses in Treatment of Typhoid Fever of Hypertoxic Type. M. E. Farinaud and L. Portes. —p. 3.

Chloramphenicol (Chloromycetin®) in Typhoid Fever.—Farinaud and Portes treated 12 patients, 10 adults and two children, with typhoid of hypertoxic type, with chloramphenicol (chloromycetin®). Four patients with temperatures of 102.2 to 105.8 F. (39 to 41 C.) for five to 14 days were given 50 mg. of the drug per kilogram of body weight as the initial massive dose and then daily doses of 50 mg. per kilogram of body weight in divided doses every two to three hours for 24 hours. Treatment failed, and all four patients died. Eight patients with the same type of fever were given on the first day a total of 15 mg. per kilogram of body weight in four divided doses every six hours. The following days the dose of the drug was gradually increased to 50 or 60 mg. per kilogram of body weight in divided doses at shorter intervals. Treatment was continued with this "useful dose" for seven days after defervescence, which was obtained usually between the sixth and seventh day of treatment. Treatment with chloramphenicol was combined with symptomatic treatment, analeptics and desoxycorticosterone, according to the condition of the patient. Seven patients recovered without recurrence, one patient had a recurrence on the eleventh day after treatment with chloramphenicol was discontinued, but recovery was obtained by the repeated administration of the drug for several days. It seems advisable to employ massive doses of the drug only in the early stages of typhoid. In the treatment of patients in the advanced stages of the disease who already show signs of intoxication or organic deficiency, chloramphenicol should be used cautiously in gradually increasing doses. This does not exclude final treatment with large doses for definite control of the fever.

59:21-40 (Jan. 13) 1951

*Resistance of Tubercle Bacillus to Paraaminosalicylic Acid (PAS). N. Rist and P. Veran.—p. 21.
Thiopental Sodium Anesthesia. G. Delahaye.—p. 22.
Observations on Evaluation of Respiratory Insufficiency According to Tiffeneau's Method of Bronchodynamic Aerosols. L. Parmeggiani and A. Pinerolo de Septis.—p. 23.

Resistance of Tubercle Bacilli to Paraaminosalicylic Acid.—Studies on the development of resistance to paraaminosalicylic acid (PAS) were carried out on tubercle bacilli from 43 patients under treatment with this drug (20 to 25 Gm. of the sodium salt daily). In vitro sensitivity tests were made before the institution of treatment and at six or seven week intervals thereafter. Some of the strains were found to be more resistant than average before therapy was started, but the number of resistant strains increased during treatment. A few strains eventually tolerated as much as 12.5 to 50 gamma of paraaminosalicylic acid per cubic centimeter. Resistance to paraaminosalicylic acid developed almost as rapidly as resistance to streptomycin. When the bacilli from a patient became resistant to 2.5 gamma of paraaminosalicylic acid per cubic centimeter, that patient no longer received clinical benefit from the drug even though he might have done so previously. In nine patients receiving paraaminosalicylic acid therapy, temporary improvement was followed by relapse within one month after the appearance of bacilli resistant to 2.5 gamma of paraaminosalicylic acid per cubic centimeter. Since paraaminosalicylic acid has proved to be a valuable drug in noncavitary forms of tuberculosis and occasionally even in cavitary forms, development of resistance to the drug must be avoided. For this reason, the drug should be given no longer than four to six weeks, and then only to patients in whom disappearance of bacilli, or at least some effect on recent nodular lesions may be expected in such a short time or in whom a preoperative antifebrile effect is desired. Paraaminosalicylic acid should then be combined with streptomycin, since combined treatment has proved to prevent resistance to both streptomycin and paraaminosalicylic acid. In cases in which streptomycin is contraindicated or in which resistance to streptomycin has developed, combined treatment with paraaminosalicylic acid and sulfonamides is recommended.

Semaine des Hôpitaux de Paris

27:247-284 (Jan. 22) 1951

*Sex Hormones and Epiphyseal Cartilage. A. Lichtwitz, G. Thiéry, R. Parlier and M. Delaville.—p. 247.
Mechanism of Action of Sex Hormones on Epiphyseal Cartilage. A. Lichtwitz, R. Parlier, G. Thiéry and M. Delaville.—p. 260.
Histophysiology of Growth. A. Lichtwitz, A. Parlier, G. Thiéry and M. Delaville.—p. 265.

Sex Hormones and Epiphyseal Cartilage.—Small doses of estrogenic compounds (2 or 4 gamma of estradiol or diethylstilbestrol in 1 cc. of olive oil) and of testosterone propionate (0.2 mg.) were administered daily for seven days to four groups of rats. The first group consisted of impuberal animals aged 11 days, the second of prepuberal animals aged 21 days, the third of puberal animals aged 3½ months and the fourth of old animals aged 650 days. The animals were killed the day after the last injection. Examination of decalcified bones of the animals showed that the estrogenic compounds as well as testosterone propionate caused multiplication of the flattened, serially arranged cells of the epiphyseal cartilage, without producing any change in the subjacent hypertrophic cartilage cells. There was lengthening of the newly

formed provisional osseous tissue. Proliferation of the flattened cells indicates future growth, while the lengthening of the newly formed provisional osseous tissue indicates that growth in length already has occurred. Testosterone propionate seemed to be inactive in the female rat, and the estrogenic compounds did not increase proliferation of the flattened cells in male rats. There is thus a sexual differentiation in the receptivity of the epiphyseal cartilage. This differentiation extends to the zone of provisional ossification. The trabeculae in this zone are thick, short, obliquely directed and anastomotic in the female animal, whereas in the male they are thin, long, parallel to the long axis of the bone and of nonanastomotic type. This arrangement is reversible under the influence of the opposite sex hormone, and one may thus produce a true masculinization or feminization of the provisional osseous tissue. The epiphyseal cartilage appeared to be much developed in the young rats aged 11 days, and its density diminished with increasing age. It is suggested that the genital steroids, and particularly the estrogenic compounds, in small doses accelerate growth by their effect on the proliferating, flattened cartilage cells. On the other hand, it is true that the estrogenic compounds have an elective effect on the hypertrophic cartilage cells, i. e., on maturation, since ossification of the zone of hypertrophic cartilage cells entails arrest of growth.

27:285-330 (Jan. 26) 1951

A Much Disregarded Symptom: Development of Xiphoid Appendage. J. Vague.—p. 285.
Prevention of Mental Diseases Through Eugenics. M. Tisserand.—p. 288.
*Considerations on a Series of 385 Extrapleural Pneumothoraces Performed in Sanatorium; Prevention and Treatment of Complications. H. Joly.—p. 291.

Complications of Extrapleural Pneumothorax.—Joly discusses prevention and treatment of complications of extrapleural pneumothorax encountered in 385 patients. Surgical intervention was performed with the patient under general anesthesia, and restoratives were used to maintain normal arterial pressure. For facilitation of pneumonolysis, a wide posterior approach was used. Hemorrhage occurs most frequently within the first 24 hours after the intervention. It may be prevented by careful hemostasis, and all small bleeding points should be coagulated. Immediate roentgenologic study is imperative postoperatively, so that any effusion may be treated by aspiration. Decrease in the blood pressure is corrected by blood transfusions. Cardiovascular collapse without pronounced dyspnea but with abdominal pain and occasionally with melena may occur about the thirty-sixth hour after the intervention. Should this collapse occur, as in five of the author's patients, it can be effectively controlled by aspiration of the effusion from the extrapleural pocket, administration of oxygen, cardiac tonics and blood transfusions. Reoperation is imperative if blood clots form in the extrapleural pocket. Parietal emphysema may be prevented if all costal arches are saved and if both ends of the sectional fragments are replaced. Cardiorespiratory failure was observed in only a few instances, although respiratory function was reduced in many of the patients. Extrapleural pneumothorax may be very hazardous and the operative result poor in the emphysematous patient and in patients with myocardial decompensation and parenchymal changes. The lesions did not extend bilaterally in any case. Entrance of air into a cavity occurred in only 11 patients, seven of whom had respiratory insufficiency. This accident is associated less frequently with extrapleural than with intrapleural pneumothorax. The 10 per cent incidence of secondary perforation of cavities and of serous effusion and empyema of the extrapleural pocket was reduced by the institution of streptomycin therapy to 3.5 per cent. Early formation of adhesions may be prevented if the patient is observed roentgenologically twice daily and not less than once every 24 hours during the first postoperative week and by frequent changing of the patient's position in bed from the left to the right side, so that a prolonged dorsal recumbent position is avoided. If adhesions form despite these precautions, they must be freed immediately by endoscopy within the first few days, and later reoperation may be required. Pneumothorax refills with positive pressure should be performed every eight to 12 days for prevention of adhesions. Residual cavities, which were observed in 6 per cent of the cases, disappeared in eight of 10 patients after repeated extrapleural pneumothorax. The follow-up period has not been long enough for a definite evaluation of late results. In the absence of empyema the pockets of pneumolysis should be maintained long enough for the collapse to be made effective, particularly with respect to cavities which would not be expected to retract. Pulmonary decortication is required for extrapleural pockets with walls thickened from prolonged effusion. Of the 385 interventions, 80 per cent apparently gave satisfactory local results. Results have not been determined in 14 per cent, and death occurred in 6 per cent.

Tumori, Milan

24:293-400 (Nov.-Dec.) 1950. **Partial Index**

*Melanotic Tumors of Mucosa of the Head and Neck. F. Pizzetti, G. Leonardelli and C. Pasini.—p. 315.

Mucosal Melanotic Tumors.—According to Pizzetti and collaborators, primary melanotic tumors are frequent in the nasal and buccal mucosa, rare in the conjunctiva and extremely rare in the paranasal sinuses, the pharynx and the upper segment of the esophagus. They have not been encountered, up to now, in the mucosa of the larynx, the middle ear and the structure adjacent to the middle ear. These tumors have the same histological characteristics as those of cutaneous melanoma, but they are highly malignant. An early diagnosis by biopsy and early extensive surgical treatment are indicated. The prognosis is grave, with an average survival time of two or three years from the beginning of the symptoms. Radical surgical treatment may prolong survival time. However, the percentage of recurrence or metastasis is very high. The authors report five cases in patients of both sexes between the ages of 24 and 65 years. The tumors were located in the nasal fossae, the maxillary sinuses, the hard palate and the conjunctiva. One of the patients was seen only in the final stage of the disease. Another had a recurrence three months after apparently adequate removal of the tumor and surrounding tissues followed by electrocoagulation. After a second operation the patient is still in good clinical condition two years after the operation. The third patient left the hospital in good clinical condition two months after the operation and did not reappear for observation. In the man with malignant melanoma of the hard palate, the highly malignant tumor developed from a melanotic spot of long duration. An early and extensive operation was followed by final metastasis and death of the patient one year later. In the woman of 24, the malignant conjuctival tumor developed during pregnancy from a small melanotic spot on the bulbar conjuctiva. Removal of the tumor followed by electrocoagulation failed. The tumor recurred during each of three pregnancies and was removed three times. The patient was observed for four years and failed to report again for observation.

Ugeskrift for Laeger, Copenhagen

112:1761-1788 (Dec. 28) 1950. **Partial Index**

*Lumbar and Suboccipital Encephalography: Comparative Study. G. Magnussen.—p. 1761.
Case of Extensive Varices in Palms of Hands: Congenital Arteriovenous Anastomoses. I. Risbjerg Johansen.—p. 1767.
Reflex Arteriospasm as Complication in Nephrectomy. H. K. Rømer.—p. 1768.

Lumbar and Suboccipital Encephalography.—Magnussen compares the results of lumbar and suboccipital encephalography in the psychiatric department of the Kommunehospital during a 21 month period and concludes that outside of special neurosurgical clinics lumbar encephalography should be the normal method. Failure of air to enter the ventricles occurs about 10 times as often with the suboccipital method as with the lumbar procedure. The slightly greater discomfort associated with lumbar encephalography is outweighed by the considerably smaller risk connected with it. Suboccipital encephalography should be done only in weakened patients, such as those with serious heart disease, or when general anesthesia is required, and should be performed only by skilled operators. In every case of encephalography, attention must be directed to possible contraindications. Before encephalography, ophthalmoscopy must always be done, but this examination is not in itself sufficient. Even slight symptoms of cerebellar disturbance constitute an absolute contraindication for encephalography.

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BOOK REVIEWS

The Urinary Function of the Kidney. By A. V. Wolf, Ph.D., Associate Professor of Physiology, Albany Medical College, Union University. Cloth. $7.50. Pp. 363, with 49 illustrations. Grune & Stratton, Inc., 381 Fourth Ave., New York 16, 1950.

Dr. Wolf is well known among those interested in renal physiology for his unusual approach to problems of fluid and electrolyte metabolism. Impressed by the infirmities in the foundations on which are based widely current views of kidney function, Dr. Wolf has entirely abandoned its analysis in terms of the discrete processes involved. Instead, he has chosen to deal directly with the over-all regulations of composition and volume effected by the kidney. Such regulation, considered distinct from excretory function, Dr. Wolf has termed the "urinary function" of the kidney. The book presents the author's critical analysis of current theories of renal function and a substitute for their discarded premises. It will be read with interest and profit by all concerned with fluid and electrolyte metabolism, for it presents a different and challenging point of view and an extensive review of the subject.

Dr. Wolf has an aptitude for elegance of expression. However, the invention of a new technical vocabulary detracts from his writing as a means of communication. The average reader, lacking familiarity with Dr. Wolf's terminology, will find it desirable to read the book from its beginning rather than to select those subjects that excite his interest. This he will find no hardship, as the book is readable and clearly written although burdened with a superfluity of mathematical derivations. The preface is essential reading for those who would understand the author's point of view.

The book includes an extensive bibliography. Although Dr. Wolf eschews analysis in terms of glomerular filtration rate, most of the pertinent information is included. Unfortunately, much of the data and conclusions from the literature have not been subjected to the same critical analysis which has been applied to methods for measurement of glomerular filtration. Noteworthy are an excellent discussion of the much misunderstood implications of the Starling hypothesis, a clear exposition of fluid transfers among body compartments and a classification and discussion of states of hydration and dehydration. Dr. Wolf's presentations of diuresis, antidiuresis and endocrines in urinary function suffer from lack of a unifying theoretical approach and become catalogues of empirical observations.

On several fundamental points, one might find grounds for debate. There is some question as to whether the steady state achieved by the continuous ingestion or infusion of various solutions over protracted periods, the basis for the author's own interpretations, bears a closer relation to normal existence than does the imposition of stresses of such magnitude as to be lethal if prolonged. The information derived from the latter observations is, however, dismissed as belonging in the field of "parapsiology." One may also wonder whether the possibility that the inulin clearance might not be precisely equal to the rate of glomerular filtration warrants abandonment of the approach to the analysis of renal function for which it is the basis.

Philanthropic Giving. By F. Emerson Andrews. Cloth. $3. Pp. 318. Russell Sage Foundation, 130 E. 22nd St., New York 10, 1950.

The author of the present volume has been a staff member of the Russell Sage Foundation for over 20 years and is thoroughly familiar with the activities of this organization, which has played an important role in the support of a number of philanthropic organizations and scientific research laboratories. This is an opportune time to call attention to the role which well endowed foundations have played in the support of many charitable and educational organizations. Had it not been for their support many worth while projects would not have been undertaken. Now that the government is encroaching to an even greater degree on territory covered by these privately endowed institutions, it is highly desirable that the public be informed concerning the methods of these foundations which have rendered such fine service. Those entrusted with the disposal of government funds would be well advised to study carefully volumes of this nature in the hope that they can accomplish their purpose as efficiently as the directors of these institutions. In this volume will be found much valuable information and also some useful data concerning the financial statements of voluntary welfare agencies. It has a number of important suggestions to offer, and, of course, points to the difficulties in insuring proper use of funds and also making a wise selection of projects. This latter point is exceedingly important at the present time since there are so many deserving projects clamoring for support. This volume should be widely read by workers in the field of educational and social welfare.

Heart Disease in Pregnancy. By A. Morgan Jones, M.Sc., M.B., F.R.C.P., Deputy Director of Department of Cardiology, University of Manchester, Manchester. With foreword by Professor Crighton Bramwell, M.A., M.D., F.R.C.P. Boards. 6s. Pp. 87, with illustrations. Harvey & Blythe, Ltd., 212 Shaftesbury Ave., London, W.C.2; distributed in U. S. A. by Grune & Stratton, Inc., 381 4th Ave., New York 16, 1951.

The author is well qualified to write this excellent monograph because of his extensive experience during the past 18 years in following through pregnancy more than 1,500 women with organic heart disease. The statistical data in this book are based principally on observations of a recent group of 485 consecutive cases. With careful medical supervision the risk of pregnancy in the cardiac patient is found to be remarkably small. The mortality for the entire group was 4.8 per cent, of which 2.8 per cent could be attributed to heart disease. Heart failure accounted for the greatest number of deaths. The maximum strain on the heart was found not to be at term, as generally supposed, but at the thirty-second week. It is also pointed out that even in normal pregnancy there is water and salt retention with an increase in blood volume and heart output. These changes are apt to be aggravated by the presence of organic heart disease. Thus, the management of confinement of patients with heart failure becomes very important and is thoroughly discussed in this book. All phases of the problem from the assessment of fitness for pregnancy through to the postpartum period are adequately and concisely handled. Despite its brevity, this book contains the necessary information for the care of a patient with heart disease and will, therefore, be of considerable value to any physician who has the responsibility for the care of such a patient.

Good Food for Diabetics. By Eleanor Record Sigel. Cloth. $2.50. Pp. 144. Harper & Brothers, 49 E. 33rd St., New York 16, 1951.

This is a handy little reference book which physicians can recommend to their patients or others who do the cooking for their diabetic patients. It is an intensely practical book with only sufficient theory to clarify the reasons for the procedures recommended. It contains the usual tables of carbohydrate values, but its principal usefulness is in the numerous recipes. Ten different breakfasts, 50 diverse luncheons and 53 varied and interesting dinner menus are presented, and there is an additional group of 59 dinner menus for those who are allowed more than one vegetable, in addition to potatoes. There is also a section on recipes which contains an interesting and varied selection of ways in which foods can be prepared for a family in which there is a diabetic member. Recipes are so framed that cooking can be done for the group as a whole and still meet the needs of the diabetic by removal of his portion of food before certain ingredients, such as gravies or dressings, are incorporated. There are hospital forms and blank pages for noting individual dietary requirements. The only adverse comment is that salad dressings made with liquid petrolatum are recommended without any warning as to the absorption of vitamins by this substance, with consequent loss to the patient.

The reviews here published have been prepared by competent authorities and do not represent the opinions of any official bodies unless specifically stated.

Monographs on Surgery 1951. Edited by B. Nolan Carter, M.D. Ph.D. Professor of Surgery, University of Cincinnati. Advisory Editors: Gynecology, Joe V. Meigs, M.D., Clinical Professor of Gynecology, Harvard University Medical School, Boston; Urology, Charles Huggins, M.D., Professor of Urology, University of Chicago; Orthopedic Surgery, Alfred R. Shands, M.D., Medical Director, Alfred I. duPont Institute of Nemours Foundation, Wilmington, Del. Cloth. $12.50. Pp. 508, with illustrations. Thos. Nelson & Sons, 385 Madison Ave., New York 17; Parkside Works, Dalkeith Road, Edinburgh 9; 3 Henrietta St., London, W.C.2, 1950.

The purpose of this book is to present a series of monographs on surgical subjects which are of interest not only to the gynecologist, urologist and orthopedic surgeon, but to the general surgeon as well. Twelve articles are included in this work.

Five papers are presented in the form of a symposium on carcinoma in situ of the cervix. Proper gynecologic examinations are stressed as being most important in the reduction of the numbers of invasive and inoperable carcinomas of the cervix uteri. The advisory editor of this section points out the fact that confusion may result from a difference in nomenclature. To avoid such confusion a glossary is appended. These five authors report on nearly 645 patients with cancer in situ.

An extensive article on cholangiography is presented. Numerous illustrative cases are shown by means of excellent roentgenographic and diagrammatic presentations.

The article on cytologic diagnosis of cancer stresses correctly the thought that negative results do not mean that the patient is free of carcinoma. The method is of greatest value in carcinoma of the lung, female genital tract and serous cavities. The authors state that in their hands the examination of gastric contents for neoplastic cells has not been satisfactory and, therefore, has been discontinued.

The urologic section deals with the diagnosis and treatment of the infertile male and the surgical management of prostatic disease. The orthopedic section includes material on the hip joint, bone tumors, the knee and arthrodeses.

The presentations of the subjects are in the main clear, concise and authoritative. The book is well printed, readable and can be recommended to anyone interested in keeping abreast with the current concepts of the topics listed in the book.

Nasal Sinuses: An Anatomic and Clinical Consideration. By O. E. Van Alyea, M.D., Associate Clinical Professor, Department of Laryngology, Rhinology, and Otology, University of Illinois College of Medicine, Chicago. Second edition. Cloth. $9. Pp. 327, with 143 illustrations. Williams & Wilkins Company, Mount Royal and Guilford Aves., Baltimore 2, 1951.

On the jacket of this book the following appears: "The prevalence of common sinus complaint in every doctor's practice guided the author in discussing only the conditions that occur regularly, and in omitting rarities and malignancies." Unfortunately for the writer of the jacket, the author obviously had other intentions. Chapter 10 on tumors deals not only with polyps, cysts and osteoma, but with malignant tumors involving the ethmoid area and the maxillary sinus. The book is marred by careless proofreading and a pronounced tendency for the author to express himself in medical jargon rather than in simple, grammatical English. These matters were perhaps excusable in the first edition, but they are more difficult to ignore in a revised edition. Despite these criticisms, this book will continue to serve as a satisfactory vehicle for up-to-date knowledge on the nasal sinuses. In addition to a discussion of newer therapeutic measures, revisions have been made in a number of chapters, especially the one on allergy.

Primer on Fractures. Prepared by Special Exhibit Committee on Fractures in cooperation with Committee on Scientific Exhibit of American Medical Association. Sixth edition. Cloth. $2. Pp. 109, with 48 illustrations. Paul B. Hoeber, Inc., (Medical Book Department of Harper & Brothers), 49 E. 33rd St., New York 16, 1951.

The format in this edition has been changed somewhat, which makes it easier to use than the previous ones. The use of the terms "open" and "closed" fractures is permanently established, and the terms "compound" and "simple" are discarded. It is refreshing to see how much actual "meat" can be packed into a small book of this type. The lack of verbiage and the simple style of presentation will continue to make this edition as appealing as have been its predecessors. Forty-eight simple but nevertheless effective illustrations amplify the text. The book is intended mainly for students and practitioners interested in fracture work. It fulfills its purpose and can be highly recommended.

Scientific Russian: A Textbook for Classes and Self-Study. By James W. Perry, Associate Professor, Modern Language Department, Massachusetts Institute of Technology, Cambridge. Cloth. $7.50. Pp. 816. Interscience Publishers, Inc., 250 Fifth Ave., New York 1, 1950.

The author is a research chemist and a student of methods of documentation. The purpose of the book is to teach a reading knowledge of scientific and technical Russian. The 800 page volume, attractively printed, is essentially a grammar. It is divided into 40 lessons. Each lesson includes a Russian reading exercise written so as to provide illustrations of those features of Russian with which the lesson is concerned. The scientific and technical nature of the reading exercises has the advantage of providing an understanding of Russian scientific writing. There is both a Russian-English and an English-Russian vocabulary. The fact that the Russians are using more and more technical terms of foreign origin, frequently preferring them to their own, should be of help to the beginner. The difficulty in acquiring a reading and speaking knowledge of Russian is due to the fact that it is probably the most highly inflectional of the European languages. The author has done an admirable job in introducing the reader to these peculiarities. The book accomplishes its purpose.

Borderlands of Science. By Alfred Still. Cloth. $3.75. Pp. 424. Philosophical Library, Inc., 15 E. 40th St., New York 16, 1950.

The author attempts to evaluate the influence on civilization of both science and superstition. In the opening chapter he endeavors to show how science has developed since about 2,500 B. C. when science was little more than a branch of philosophy. The spirit of modern science came into being with Kepler, Galileo, Descartes and Newton. Experiment then was no longer forbidden, and it was deemed necessary as a means of confirming conclusions derived from reason. The world of science, the author states, even today is a world of appearance. The scientist "has no business to assume that what he refers to as the material world is a real world." In the electronic age of today, the scientist is more of a philosopher than he was a half century ago. He is inclined to admit that the end of his intellectual journey cannot be reached, and the ultimate value of his wayside discoveries cannot be known.

After the introductory chapter, the "borderlands of science" are discussed in chapters on "Magic and the Mystic," "Science from Magic," "Magic and Science of the Seventeenth Century," "Witchcraft and the New Science," "Man and the Universe," "The Divining Rod," "Levitation," "Poltergeist Phenomena and Telekinesis," "Body, Mind and Memory," "Hypnotism and Clairvoyance," "Telepathy," "Time and Recognition," "Faith Healing," "Spiritualism," "Talismans and Charms." In these chapters, the author uses many quotations from other writers on these obscure subjects. He seems to believe that science should undertake a genuine and comprehensive investigation of these borderlands of science.

The author apparently is an electrical engineer, although neither the book nor the jacket give any biographic data. According to "American Men of Science" he was born in England 82 years ago and was professor of electrical engineering at Purdue University for many years.

Histamine Antagonists. By Frederick Leonard and Charles P. Huttrer. National Research Council, Chemical-Biological Coordination Center, review no. 3, Paper. $1.50. Pp. 122. National Research Council, 2101 Constitution Ave., N.W., Washington 25, D. C., 1950.

This monograph attempts to show the effect of various types of chemical structure on the antihistaminic activity of a drug. The antihistamines are classified into the following groups: alkylenediamines, aminoalkyl ethers, alkylamines, haloalkylamines, aminoketones and secondary aminoalcohols, aminoalkylesters and unclassified compounds. Tables are presented of the structural formulas of the antihistamines used clinically and of more than 1,100 other antihistamines on which there is some pharmacological data. The activity of each drug is assigned a value ranging from 0 to 6. This volume will be of inestimable value to pharmacologists, chemists interested in the antihistamines and to many physicians and others interested in the relation of chemical structure to physiological action.

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Atlas of Histologic Diagnosis in Surgical Pathology. By Karl T. Neubuerger, M.D., Professor of Pathology, University of Colorado School of Medicine, Denver. With section on Exfoliative Cytology. By Walter T. Wikle, B.S., M.S., M.D., Assistant Professor of Pathology, University of Colorado School of Medicine, Denver. Cloth. $11. Pp. 460, with 880 photographs by Glenn E. Mills, B.A., M.A. Williams & Wilkins Company, Mount Royal and Guilford Aves., Baltimore 2, 1951.

The author points out in the preface that residents in pathology, surgery, gynecology and other specialties, physicians who are confronted occasionally with the problem and those preparing for the examinations of the specialty boards encounter difficulties in making histopathological diagnoses of surgical specimens and biopsies. The aim of the atlas is guidance by means of photomicrographs and brief text in arrival at a diagnosis. There are 880 photomicrographs, 3 by 3½ inches in size, each accompanied by a brief description and short clinical notes. Diagnoses are printed in large type, and in many instances pictures with low magnification are accompanied by larger magnifications of significant parts of the field. The presentation is by systems, such as integument, respiratory system, endocrines, alimentary canal and associated glands, urinary and genital systems, nervous system. The section on exfoliative cytology is similar but with larger illustrations.

Since the photomicrographs are made from routine material, their quality is not uniformly good. In many instances the magnification is so low that details described in the text are not clearly visible, but in some cases a companion picture at larger magnification is helpful in this respect. The legends are often too brief, sometimes to a point below that which would appear on a laboratory index card. The clinical notes are often so condensed as to be of little value.

The book is made of a series of illustrations from an unusually extensive collection of material and is, therefore, comprehensive. It is an atlas, to be sure, but an atlas without sufficient explanation of its contents. The section on exfoliative cytology is excellent, but it adds nothing important to illustrative material in numerous readily available books on the subject.

Philosophically, there is question as to whether the approach used in this book can fulfill its declared purpose, a feature which would be common to any similar compilation. A Chinese picture may be better than a thousand words, but that is not true of a pathological lesion. No atlas or even book can substitute for training and experience. So much in medical practice depends on exact pathological diagnosis that it is difficult to accept or condone expedients or short cuts.

Common Skin Diseases. By A. C. Roxburgh, M.A., M.D., B.Ch., Consulting Physician and Lecturer, St. John's Hospital for Diseases of Skin, London. General practice series. Ninth edition. Cloth. 25s. Pp. 505, with 223 illustrations. H. K. Lewis & Co., Ltd., 136 Gower St., London W.C.1, 1950.

This is an extremely practical textbook and manual of dermatology for the general practitioner. The author presents a systematic method of approach to the diagnosis of skin diseases, outlining in detail technics of history taking and examination and providing extensive tables of differential diagnosis based on the morphology of skin lesions. After this the common skin diseases are grouped according to cause or morphology, discussed concisely and illustrated adequately. Special emphasis is placed on differential diagnosis and on simple methods of therapy which are usually available to the general practitioner. Numerous prescriptions are presented. Although this textbook employs the terminology of the British Pharmacopoeia and occasionally lists proprietary drugs of British manufacture, this is not a major objection from the viewpoint of the American practitioner since the American equivalent is usually readily apparent or easily obtainable. The excellent organization of the material, clearly indicated in the table of contents, in the differential diagnostic index and in the chapter subheadings, facilitates rapid reference. The author makes no claim to encyclopedic completeness. Rare and tropical dermatoses are not included, nor are discussions of the anatomy and physiology of the skin or the treatment of syphilis. Recent advances in therapy are included in this edition. This volume is recommended as a practical introductory textbook and manual of differential diagnosis and therapy.

Pharmacology. By Michael G. Mulinos, M.D., A.B., A.M., Associate Professor of Physiology and Pharmacology, New York Medical College, Flower and Fifth Avenue Hospitals, New York. With foreword by Charles C. Lieb, A.B., M.D. Second edition. Cloth. $5. Pp. 484. Oxford University Press, 114 5th Ave., New York 11, 1951.

The first edition of this outline appeared in 1944. According to the preface the purpose of the book is "to present a concise yet complete exposition" of the science of pharmacology "designed to bring the practitioner of medicine up to date in this complex and rapidly growing field." Unfortunately the author has fallen short of his goal. It is surprising to find no mention of the therapeutic use of cortisone or adrenocorticotropic hormone in a book with a 1951 publication date. There is no discussion of sulfamerizine, sulfamethazine or of the use of sulfonamide mixtures. The matter of dosage schedules for penicillin is inadequately considered, and no mention is made of procaine penicillin. The newer 8-aminoquinoline antimalarial drugs are not included, and no reference is made to the use of chloroquine phosphate or aureomycin in amebiasis. Other comparatively new drugs that apparently have been over looked include trimethadione, diphenylhydantoin sodium, tubocurarine chloride, mercaptomerin sodium, hetrazan® (1-diethylcarbamyl-4-methyl piperazine dihydrogen citrate) and miracil D® (1-methyl-4-diethylaminoethylaminothioxanthone hydrochloride). The half life of radioactive phosphorus, P^{32}, is incorrectly given, and the term MLD_{50} is used instead of LD_{50}. Evidently, no attempt was made to conform to the current editions of "Pharmacopeia of the United States," "The National Formulary" or "New and Nonofficial Remedies." It is to be regretted that the author had not done a finished revision since one of the advantages of a short manual is that it can readily be kept up-to-date and thus offset the necessary sacrifice of detail.

Elements of Psychoanalysis. Edited with an Introduction by Hans Herma, Ph.D., and Gertrud M. Kurth, Ph.D. Sol W. Ginsburg, M.D., Advisory Editor. Foreword by C. P. Oberndorf, M.D. Cloth. $3. Pp. 333. The World Publishing Company, 2231 W. 110th St., Cleveland 2, 1950.

This book is a collection of papers written by outstanding leaders in the fields of psychology and psychiatry. Material is presented in a form suitable for the intelligent layman who is attempting through increased knowledge to more effectively face personal, family and social problems of living. Contributions have been made by Franz Alexander, Anna Freud, Karl Menninger and other well known authorities in psychoanalysis.

Problems are presented in a manner that provides insight and guidance through the examination of examples of distorted lives and discussion of the dynamic elements of personality which enter into these distortions. Problems relating to alcohol, impotence, frigidity, homosexuality, criminology and basic difficulties of childhood are discussed. The book includes an interesting compendium of common misunderstandings of psychoanalysis and an explanation of such errors. A chapter concerning problems of present day marriage and divorce seems particularly interesting.

Functional Anatomy of the Limbs and Back: A Text for Students of Physical Therapy and Others Interested in the Locomotor Apparatus. By W. Henry Hollinshead, A.B., M.S., Ph.D., Head of Section on Anatomy, Mayo Clinic, Rochester, Minnesota. Cloth. $6. Pp. 341, with 122 illustrations. W. B. Saunders Company, 218 W. Washington Sq., Philadelphia 5; 7 Grape St., Shaftesbury Ave., London, W.C.2, 1951.

This book satisfies, beyond a doubt, all its claims as a textbook for beginning students of physical therapy and others interested in the locomotor apparatus. The author carries considerable authority and his material much weight. The book is a textbook in character. The author's purpose is to provide a readable account of that portion of the anatomy which is of particular interest to those concerned with the functions of the muscles and movements of the body. It is to be used primarily by students who have only a slight background in biology and as an introduction to formal training in human anatomy. The essential anatomy is described simply but authoritatively. It is written for the beginning nonmedical student. The author has drawn material from many sources. The style of writing is simple; the illustrations are excellent. The book can be recommended without hesitation for those for whom it was intended.

Orthopaedic Nursing. By Frederick J. Knocke, M.D., Adjunct Orthopaedist, Lenox Hill Hospital, New York, and Lazelle S. Knocke, R.N., B.S., Clinical Instructor in Orthopaedic Nursing, Hospital for Special Surgery, New York. Cloth. $5. Pp. 682, with 312 illustrations. F. A. Davis Company, 1914-16 Cherry St., Philadelphia 3, 1951.

This textbook is designed primarily to help the student nurse acquire fundamental facts, principles and attitudes which will aid her in solving problems that she will meet while learning to understand and care for persons with orthopedic disabilities.

A basic tenet in the philosophy of the authors is that the sick person, in this case one orthopedically handicapped, is a person who must be treated as a whole. This is a desirable concept applicable to every phase of nursing education. Also stressed to properly implement the needs of a patient other than those of immediate medical care is the importance of an understanding and appreciation of interprofessional and interagency services. Not to be overlooked in the training of student nurses is the all important fact that on the earnest endeavors of the patient himself depends to a large degree his physical, psychosocial and vocational rehabilitation.

Rather than discourses on the nursing care of each specific disease entity, the common basic problems of orthopedic nursing are considered, the subject of poliomyelitis being the only exception to this method of approach. Otherwise, orthopedic examination and treatment and the descriptive diagnosis, etiology, course and treatment of the commoner orthopedic conditions have been presented as a separate unit. Personal posture and body mechanics are reviewed, and the application of these appear throughout the text.

Eight contributing authors have participated in writing various sections. For the use of the nursing instructor, each chapter is followed by a list of questions for study and discussion, reference sources and audiovisual aids.

This book effectively introduces the student to the unique problems in the care of the orthopedic patient and provides her with the means to approach, analyze and solve these problems. Such important concepts as the whole person, interagency and interprofessional cooperation and rehabilitation are so described and correlated throughout that the student cannot fail to see their application not only in the field of orthopedic nursing but also generally in all other types of nursing care. This book is highly recommended.

The Science of Health. By Florence L. Meredith, B.Sc., M.D. Second edition. Cloth. $3.75. Pp. 452, with 134 illustrations. The Blakiston Company (Division of Doubleday & Company, Inc.), 1012 Walnut St., Philadelphia 5, 1951.

This is a college textbook designed for use in the hygiene courses in which the time allotted for presentation is brief, but in which comprehensive evaluation of the value of personal and public hygiene is desired. This book appears well adapted to the college level and gives about the right amount of anatomy and physiology to help college students understand the reasons behind certain recommended personal hygiene practices. Many simple illustrations are used to explain physiological functions, as well as the changes in these functions associated with disease or injury.

The section covering the major health problems in the United States gives a concise but clear discussion of the communicable diseases, the more important noncommunicable diseases and the preventive aspects of mental health. The discussion on mental health is more complete than that found in most college textbooks and in easy stages traces through the health of the brain and nerves to personality development and its protection, into the identification of one's self as a person, a member of society and a member of a sex. The emotional aspects of sex are closely related to the anatomy and physiology of reproduction which is simply but carefully explained.

This is, in all, a good college textbook which is not too technical and yet is sufficiently technical to stimulate the interest of college level students in personal and community health and give them the correct words to use in discussing health problems. It is too elementary to be useful to physicians, but it could be used by them in helping develop the understanding of young adults.

Bacterial Polysaccharides: Their Chemical and Immunological Aspects. By Martin Burger. Cloth. $6. Pp. 272. Charles C Thomas, Publisher, 301-327 E. Lawrence Ave., Springfield, Ill.; Blackwell Scientific Publications, Ltd., 48 Broad St., Oxford, England; Ryerson Press, 299 Queen St., W., Toronto 2B, 1950.

This book is a concise collection of the data available in the literature on polysaccharides related to infection and immunity. The carbohydrates may reside in certain pathogenic bacteria or be produced by them during metabolism.

The volume contains 13 chapters, most of which discuss the polysaccharides produced by certain classes or groups of bacteria. The chapters are usually subdivided into three categories. A brief historical introduction, a section on isolation which is usually chronological in organization and finally the chemical and immunological characteristics of the polysaccharides are discussed. Among the polysaccharides treated are those produced by anthrax, Brucella, Neisseria, pneumococci, staphylococci, streptococci and vibriones. Dysentery bacilli, mycobacteria, Hemophilus, Salmonella, Eberthella typhosa and the more important Klebsiella, Escherichia, Aerobacter and Proteus polysaccharides are also included. Each chapter has an appropriate bibliography and the book contains an author and subject index. An appendix containing a variety of procedures for the isolation of bacterial polysaccharides is also included.

The book should be of interest to the medical profession in general, but will probably be of the greatest interest to those in the fields of bacteriology, serology and immunology.

Amino Acids and Proteins: Theory, Methods, Application. Compiled and edited by David M. Greenberg, Ph.D., Professor of Biochemistry and Chairman of Division, University of California School of Medicine, Berkeley, California. Cloth. $15 Pp. 950, with illustrations. Charles C Thomas, Publisher, 301-327 E. Lawrence Ave., Springfield, Ill.; Blackwell Scientific Publications, Ltd., 49 Broad St., Oxford, England; Ryerson Press, 299 Queen St., W., Toronto 2B, 1951.

This new book is a monograph on the biochemistry of most proteins and all the amino acids. It consists of a compilation of 13 chapters contributed by 18 experts, including the editor, and summarizes early and recent developments in this field as an aid to evaluation of the properties and functions of proteins by students and investigators. Chemical and physical methods employed for the determination of the characteristics of proteins receive the major emphasis. The book will not appeal to many practicing physicians, but the sections on the nutritional, metabolic, osmotic and immunologic aspects of proteins will be of interest to clinicians. The proteins and protein products of significance in medicine include plasma proteins, hormones, enzymes and certain antibiotics and viruses. Enzymes are purposely not considered because of lack of space that would be required to cover them adequately. Each chapter is concluded with a comprehensive bibliography of numbered references listed alphabetically by authors without titles. The numbers correspond to citations in the text. The alphabetic arrangement by authors is distorted in the list at the end of the last chapter by two final entries. The index includes both authors and subject matter and is carefully compiled. The binding, typography, formulas, tables, illustrations and paper are excellent.

Fifty Years of Medicine: A Symposium from the "British Medical Journal." Cloth. 15s. Pp. 330, with illustrations. British Medical Association, Tavistock Square, London, W.C.1; distributed in U. S. A. by Grune & Stratton, Inc., 381 4th Ave, New York 16, 1950.

This book is a reprint of the numerous articles, editorials and pictures which appeared originally in the *British Medical Journal* of Jan. 7, 1950. The articles which were written by outstanding authorities in various fields comprise an excellent summary of medical progress in the 50 years after Jan. 1, 1900. Fortunately, this important material has been reset in larger type than that used in the *British Medical Journal*. The unusual number of editorials are assembled in the opening chapter and are followed by the original signed articles in the order in which they first appeared. The book is a convenient size and well deserving of a place in physicians' libraries. From the standpoint of makeup, it suffers from one practice, which seems to be becoming commoner among printers, that is, the beginning of a new section or paragraph at the bottom of a page, sometimes with space sufficient for only one line of type.

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QUERIES AND MINOR NOTES

OBSTETRIC FACILITIES FOR AN AIR FORCE BASE

TO THE EDITOR:—*Please send me a comprehensive plan for setting up two delivery rooms, including equipment. We are in the process of establishing obstetric facilities for the dependents of the Langley Air Force Base personnel. We anticipate about 60 deliveries per month.* *M.D., Virginia.*

ANSWER.—The delivery rooms should be in a maternity unit and separate from the surgical and medical departments. Separate labor and delivery room units, with separate equipment, should be maintained for the delivery of normal patients and infectious patients. There should be adequate isolation facilities for mothers having or suspected of having any infection. No service of the hospital into which any infectious material is brought should be located in the maternity division. All nurseries and rooms for isolation, formula, examining, labor and delivery service should have adequate and readily accessible facilities for the scrubbing of hands. The running water in these rooms should be controlled with arm, knee or foot. In addition, the aforementioned rooms should have adequate and appropriate receptacles for the efficient disposal of soiled linen, diapers and waste, which should be promptly removed. All utensils, such as bedpans, coming in contact with the patient, should be individual and should be adequately cleansed and sterilized after each use. All material coming in contact with any possible source of infection in either the mother or the infant should be destroyed or properly sterilized, transported and stored in an aseptic manner before subsequent use.

The personnel engaged in obstetric service should be limited for their term of service strictly to obstetric duties. The personnel should be examined at regular intervals for infectious and communicable disease. Personnel reporting off duty because of illness should be reexamined and cleared by a physician before returning to obstetric duties. Obstetric nurses must not attend necropsies.

The delivery room should be of such size as to provide for easy movement in all emergency situations that may arise. The smallest adequate dimensions are 15 by 15 feet. The door to the delivery room should be so constructed that it is hinged to swing in two directions and wide enough to provide easy ingress and egress of a patient's bed. The door should contain a glass panel, so that observation of the room's content can be made from outside the room. The floor of the room should be constructed of such material that rapid and effective cleaning can be accomplished with ease. Window space should be maximum, greater than 20 per cent of the floor space, and so constructed that direct drafts on the parturient mother are avoided. Air conditioning is desirable but not mandatory. The delivery room should be equipped with mechanical aids for detection of the temperature and humidity of the room. The temperature should never be lower than 75 F. The humidity should be kept high, about 50 per cent if no measures are taken to provide an atmosphere of higher humidity for the newborn baby. Electrical switches and outlets should be constructed so that they are explosion proof. A large wall clock with a sweeping second hand should be easily visible to the obstetrician. Adequate overhead lighting should be present with auxiliary floor spotlights.

The equipment of delivery rooms should be limited to instruments and supplies necessary for routine care but adequate to meet emergencies. All other supplies should be kept in adjacent supply rooms. All labor and delivery units should be equipped with stimulants, oxygen, heat lamps or other warming devices, properly safeguarded, and all other necessary equipment. Blood transfusion apparatus should be provided as part of the delivery room equipment. Each maternity division should have immediate access to plasma or serum. A set of tracheal catheters should always be available and in good condition for use. Oxygen, with or without carbon dioxide, should be available, and the tanks should be periodically inspected so that these valuable means of resuscitation will not be unexpectedly depleted or otherwise not in usable condition. Adequate means of resuscitation of the asphyxiated newborn should always be readily available in the delivery room. It is desirable to provide an incubator in the delivery room into which the newborn infant may be placed and provided with oxygen, heat and high humidity. The newborn infant should be transported to the nursery in such an incubator if the infant's condition is poor.

Minimal equipment for a delivery room should include the following items:

- Apparatus, for anesthesia, including spinal tray, and for blood pressure
- Antiseptics, also 70 per cent alcohol
- Ice bags and hot water bottles
- Bassinet, heated, with pad, rubber sheet, linen and blanket for newborn
- Basin for placenta
- Bed or table for delivery with accessory equipment, stirrups, shoulder braces and hand holders
- Blankets, nonwoolen
- Cabinet, instrument
- Clock
- Cupboard, linen
- Equipment, oxygen
- Instruments
  - Forceps
    - Allis
    - artery
    - obstetric
    - packing
    - ring
    - tenaculum
    - tissue
  - Craniotomy set
  - Duhrssen's set
  - Sutures and ligatures
  - Needles, assorted surgical
  - Retractors
  - Rubber suction bulb
  - Scalpel
  - Scissors
  - Speculums
  - Urethral catheters—plain, Foley
- Linens—sheets, drapes for scrub table, crib and patient
- Mattress or pad (sectional)
- Packing material (8-10 yards) in jar, autoclaved
- Pillow
- Receptacle, waste
- Sheet, rubber
- Spotlight
- Stands, two-basin, for hand solutions
- Stethoscope, head
- Stool, anesthetist's operator's—adjustable
- Table, anesthetist's dressing instrument
- Transfusion apparatus
- Tray, hypodermic, with medication for the control of hemorrhage, such as pituitary extract, ergonovine preparations, and respiratory and circulatory stimulants, such as epinephrine, digitalis and caffeine.

If the labor or delivery room is unavoidably used for the delivery of an infectious mother, the room and the equipment shall be thoroughly cleansed and aired before being used for another delivery. The anesthetist should take all the precautions of surgical cleanliness and should see that the anesthetic mask is satisfactorily disinfected before and after use. The delivery room should be conducted in strict accordance with surgical technic, including removing of street clothes and the wearing of effective masks, caps and gowns by everyone present.

If, on admission, evidence is found that the patient has an infection or a communicable disease, or develops such evidence after admission, she should be removed from the clean obstetric division. Any patient who comes to the hospital already delivered should be considered infectious and should not be admitted to the clean maternity division.

All washable linens used for mothers in the maternity division should be kept separate and should be washed separately from the linens used in other parts of the hospital. Any linen contaminated with infectious material should be sent to the laundry separately, properly labelled "infectious," and sterilized by boiling in water for 15 minutes, or by other approved methods of sterilization, before being returned to the maternity division and used.

The answers here published have been prepared by competent authorities. They do not, however, represent the opinions of any official bodies unless specifically stated in the reply. Anonymous communications and queries on postal cards cannot be answered. Every letter must contain the writer's name and address, but these will be omitted on request.

CESAREAN SECTION

To the Editor:—*1. The question of repeat cesarean section arouses much controversy. What is your opinion? 2. In a pregnant women with a rheumatic heart and a history of decompensation, why is a 40 minute operation better for the patient than a labor of several hours' duration? 3. A patient, gravida III, has type O, Rh-negative blood. The Rh antibody titer was positive in dilutions of 1:1,024 and 1:2,048 four months and three months, respectively, prior to the expected date of delivery. She has had two previous cesarean sections. When should she be delivered?*

John Purney, M.D., Bristol, Conn.

Answer.—1. The mortality rate for repeat cesarean sections is at most 0.5 per cent. In at least two hospitals in the United States there have been more than 1,000 consecutive cesarean sections without a single death from any cause. There is a definite risk of death from rupture of the uterus, and, of course, there is a distinct danger of rupture of the uterus following cesarean section. After cervical cesarean section, the ruptures occur almost entirely during labor. In these cases, since the patients are in hospitals, the diagnosis is made early and operation is resorted to quickly. Therefore the death rate in these cases is low. On the other hand, when rupture of the uterus takes place during pregnancy, as often occurs after the classic cesarean section, there is delay in operation and consequently a higher mortality.

Cosgrove (*Bull. Margaret Hague Maternity Hosp.* **3**:14, 1950) reported that of 100 women admitted at or near term with a history of previous cesarean section, 45 were delivered vaginally without maternal mortality or without serious complication. Furthermore, there was no maternal death due to rupture of the uterus after cesarean section in more than 100,000 live births. On the other hand, reports from Bordeaux and Chile indicate how dangerous it may be to permit vaginal delivery after cesarean section. According to J. P. Greenhill (1950 Year Book of Obstetrics and Gynecology, Year Book Publishers, page 203) Rivière, Soumireu and Boireau studied the records of 55 women who had cesarean sections and who returned for 83 subsequent deliveries. There were 34 repeat cesarean sections and 49 deliveries through the vagina, with three ruptures during a test of labor. The figures for rupture should be based only on the 49 deliveries from below, making the incidence 6 per cent, which is high for rupture of the uterus following cesarean section.

The death rate following rupture of the uterus is high. In the series of 42 cases reported by Fitzgerald, Webster and Fields (*Surg., Gynec. & Obst.*, **88**:652 [May] 1949) the maternal mortality was 54.76 per cent.

2. A 40 minute operation is definitely less harmful than a vaginal delivery, even if the latter does not last many hours and is not excessively painful. However, the trouble with a cesarean section is not the operation itself, which can easily be performed under local anesthesia with almost no risk whatever, but what may happen as a result of the operation and afterward. For example, during cesarean section there is nearly always more blood loss than during vaginal deliveries, and there is more possibility of shock and increased possibility of disturbances in the vasomotor balance. After operation there is surely a greater opportunity for gastric and intestinal distention, which may embarrass the heart, and there is definitely increased danger of large or small emboli after abdominal surgery. For all these reasons an abdominal operation is usually of greater risk than vaginal delivery in women with heart disease. In most women with heart trouble the baby can be delivered vaginally shortly after complete dilatation of the cervix under local anesthesia.

3. This patient should be delivered about 10 to 14 days before term, not because of the likelihood that the baby will have erythroblastosis, but because the patient had two previous cesarean sections. There is not much sense in one's delivering a baby several weeks before term in the hope that the baby will not be too strongly damaged by erythroblastosis and, therefore, will survive, because what one usually does in such cases is to add the penalty of prematurity to the serious illness the baby already has. The baby may not survive because of its prematurity and not because of erythroblastosis. Furthermore, despite a high titer a baby occasionally may be delivered at term and will survive practically unscathed. However, not all authorities agree with these statements; some advise performing a cesarean section at about 37 weeks in the hope of delivering a baby that is not too seriously damaged by the erythroblastosis.

POSTOPERATIVE COUGHING

To the Editor:—*An effective cough is the key to the prevention of pulmonary complications dependent on atelectasis immediately following operation and anesthesia. Please list all drugs that could be safely injected intravenously for the purpose of inducing a postanesthetic paroxysm of coughing.*

Barrett A. Greene, M.D., Brooklyn.

Answer.—There are no safe and effective drugs available that may be injected intravenously for the purpose of inducing a postanesthetic paroxysm of coughing. However, the idea is interesting. Patients who have been deeply anesthetized with an agent of long-lasting effect, such as ether, could hardly be expected to be made to cough by any means other than the use of suction in the trachea or by some mechanical irritation of the larynx. Possibly some type of irritating gas could be administered by inhalation to accomplish this purpose. Generally speaking, it is wiser to administer an anesthetic agent that would allow the patient to recover consciousness soon after the operation; one could then encourage the patient to cough voluntarily. This is an effective method. It usually is successful except in children and completely uncooperative adults.

There is something to be said for certain maneuvers, such as periodic lowering of the patient's head below the level of his hips and turning the patient from side to side to encourage postural drainage. Some benefits are believed to be obtained from the patient's postoperative inhalation of a mixture of 5 per cent carbon dioxide and 95 per cent oxygen. There are patients for whom it is undesirable to undergo paroxysm of coughing; such patients require gentle treatment. Hence, even if a drug were developed for intravenous use that would produce paroxysm of coughing, it would find limited application.

SYSTOLIC MURMUR IN RHEUMATIC HEART DISEASE

To the Editor:—*Does a blowing apical systolic murmur in rheumatic heart disease disappear completely in some cases after the acute manifestation and between subsequent recurrence?*

M.D., Illinois.

Answer.—A systolic murmur in rheumatic fever may indicate organic involvement of the valves in the form of a verrucous involvement, but it must be distinguished from murmurs due to associated fever or anemia or cardiorespiratory factors. Persistence after cessation of rheumatic activity of a long, rough, loud systolic murmur over the apex with radiation into the axilla, unaltered by deep respiration or change of position, indicates that it may be due to organic mitral disease. A systolic murmur heard early in the disease may completely disappear with subsidence of signs of activity. Occasionally, even a mid-diastolic murmur heard in the early stage of the disease has been reported to disappear after cessation of the rheumatic attack.

BRONCHIAL ASTHMA

To the Editor:—*Please give an opinion on the effectiveness of iod-ethamine® in liquefying the tenacious sputum of bronchial asthma?*

Clifford H. Kalb, M.D., Milwaukee 3.

Answer.—Iod-ethamine® is ethylenediamine dihydroiodide ($C_2H_4[NH_2]_2.2HI$). The amount of iodine in this compound is slightly more than that in potassium iodide. The two compounds should be similar in their action. This activity includes the ability to stimulate the bronchial mucous glands to secrete a thin sputum. Since potassium iodide is one of the most useful drugs in asthma, it would be expected that ethylenediamine dihydroiodide would also be effective in this disease. There is no reason, however, to expect that this drug has any particular advantage over the inorganic iodides.

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TETANUS IN DUTCH WEST INDIES FOLLOWING TRIPLE TOXOID

To the Editor:—*An 8 year old child was inoculated with triple toxoid (diphtheria-tetanus-pertussis); the next day she entered the hospital with typical clinical tetanus with high temperature. Twelve hours later the child died. A 5 year old girl entered the hospital with tetanus. She was inoculated with triple toxoid two weeks previously. The child died three days after admission. In a 3 year old girl tetanus developed 10 days after the inoculation. This child recovered. With respect to the three cases (a) the children were girls; (b) all were vaccinated once with a triple vaccine (they came from different parts of the island and were vaccinated by different physicians) and (c) none of the children had wounds. Is it possible that tetanus can develop after inoculation with a toxoid?*

A. van der Sar, M.D., Dutch West Indies.

Answer.—With respect to the cases described, there are various possible explanations:

1. The vaccine as a nonspecific tissue debilitant, favoring the occurrence of "metastatic tetanus." A latent focus of infection, harboring spores of Clostridium tetani engulfed within phagocytes, could function as a reservoir for an indefinite period. The nonvegetative spores, transported by phagocytes to a point of lessened resistance, such as the site of injection of triple vaccine, could be transformed into vegetative C. tetani, capable of forming the specific toxin (tetanospasmin) responsible for the neurological manifestations of tetanus. The "tissue debilitant"—triple vaccine in this particular problem—functions by shutting off diffusion of oxygen from the blood capillaries, thus facilitating the conversion of tetanus spores into vegetative bacilli. It is significant that spores of C. tetani may remain latent and be responsible for appearance of the disease after an operation at sites distant from the nidus of persistent infection ("bacterial metastasis"). A number of cases are on record in which tetanus occurred up to 14 years after the presumed entry of the spores into the tissues.

2. The vaccine as a source of tetanus toxin and spores. (*a*) Preformed toxin in the vaccine could account for the rapid onset and course of the disease in the one patient. Incomplete conversion of toxin into toxoid by the manufacturing process employed, with large amounts of free toxin in the fluid injected, could adequately explain the fulminating course of the disease. The implications of this possibility have far reaching effects. (*b*) Tetanus spores, in the cases of the two patients who showed signs of the disease 10 and 14 days after the injection, would lead to the picture of "incubated tetanus" described. As to the differences in clinical outcome, multiple factors, other than the amounts of toxin liberated, could play significant roles.

3. Accidental introduction of spores into the tissues from sources other than the vaccine: (*a*) inadequately prepared skin (dirt with spores on surface of the body) or (*b*) improperly sterilized syringes and needles (insufficient boiling or autoclaving).

4. Coincidental infection at other sites must be considered, making it necessary to study the actual incidence of tetanus at the time. This is not a very probable explanation, and it should be entertained only after exhaustive attempts have been made to rule out the other possibilities mentioned.

The following measures are offered to avoid additional cases of tetanus emanating from the procedure already indicated:

1. Test all vaccine for toxicity before release (animal studies).

2. Autoclave all needles and syringes.

3. Use separate small sterilizer (not used for surgical instruments) if autoclaving is not practical. The needles and syringes must be boiled for at least one-half hour.

4. Careful preparation of the site of injection: plenty of soap and water, and minimal reliance on antiseptics.

5. As a public health measure, sampling of the soil for regional distribution of spores of C. tetani, as a guide to special precautions in areas with high incidence of soil content. This measure would be designed primarily to protect against the occurrence of "metastatic tetanus." At present, there seems to be no practical program to guard against the occasional case of this type. This accepted limitation poses the problem of combined passive-active immunization, i. e., antitoxin to protect the patients under such circumstances during the process of inoculation with vaccine. Combined passive-active immunization is still the subject of controversy, the consensus at present favoring its abandonment except in subjects who have been actively immunized previously.

Immunity against tetanus does not exist in the newborn, unless the mother has received immunity from recently injected antitoxin or active immunization from tetanus toxoid. Repeated attacks of clinical tetanus do not confer active immunity.

LEG PAINS IN CHILDREN

To the Editor:—*I have had three patients, 6, 6 and 3 years of age, who complained of severe leg pains, especially in the pretibial area. The parents state that the children screamed with pain. In most cases, the pains were relieved by aspirin, heat or massage of the legs. Physical examination revealed nothing essentially abnormal. The children are well and active and have no fever and no other complaints. One 6 year old has a known congenital murmur, but there has been no history of rheumatic fever, chorea or so-called rheumatic equivalents in any of them. Can you offer information as to etiology?*

M.D., New York.

Answer.—Leg pains in children are a common complaint. The pains are usually not specific in location, nor do they usually involve joints. Rheumatic fever should be considered as a diagnosis in any child with a presenting complaint of leg pains. In the absence of findings corroborative of rheumatic fever (erythrocyte sedimentation rate, fever, joint swelling or tenderness, electrocardiographic changes), other abnormalities must be searched for. Bone and joint disease (tumors, infections, disturbances of growth, trauma) should be excluded. Myositis, local soft tissue trauma or inflammation may also give rise to this complaint. If no cause can be elicited at the site of pain, it is well to consider poor posture as the cause. Postural strain in an active child during the phase of rapid growth, when bone may be growing faster than muscle, frequently results in leg pain. Such a child frequently exhibits lordosis, with mild pes planus. If the pes planus is pronounced, correction with shoe lifts may result in relief of pain. If the posture is generally poor, corrective exercises should be undertaken (Brenneman: Practice of Pediatrics, Hagerstown, Md., W. F. Prior Company, Inc., 1948, vol. 1, chap. 13, p. 29). The use of quinine for relief of night cramps has met with some success in adults (Moss, H. K., and Herrmann, L. G.: *J. A. M. A.* **115**:1358 [Oct. 19] 1940). Its use in children has not yet been evaluated. Palliative therapy for the acute attack consists of massage and local heat. Acetylsalicylic acid is also useful.

CONTROL OF PETIT MAL

To the Editor:—*A 27 year old primigravida is two months pregnant. A diagnosis of petit mal epilepsy confirmed by encephalogram was established in 1949. The patient was given trimethadione (tridione®) and remained symptom free for two months, after which secondary anemia developed, which responded to treatments with liver and iron. Trimethadione therapy was discontinued and paradione, 0.3 Gm. twice daily, was substituted. The patient has been on this regimen for 10 months and had mild seizures on three occasions following physical and mental exposure. Would it be safe to continue, and what course is to be expected?*

Joseph Shafer, M.D., Los Angeles.

Answer.—Whether trimethadione was responsible for the secondary anemia is questionable. Adults usually require at least 0.9 Gm. a day of trimethadione or paramethadione for the control of petit mal (pyknolepsy). However, the patient's blood must be examined at least monthly and the medicine discontinued if neutrophils fall below 1,600 per cubic millimeter or if the number of thrombocytes is noticeably diminished. These medicines should not be continued indefinitely after control of attacks and clearing of spike-wave complexes from the electroencephalogram is attained.

TOXICITY OF TAPE AND OIL REMOVER

To the Editor:—*Purified benzene and carbon tetrachloride are used frequently as a tape and oil remover to reduce fire hazard. How dangerous would this solution be in such instances? Also, carbon tetrachloride is advised for removal of oil and dirt from material to be brazed, and on tools before silicone (silicate) is used to lubricate and prevent rusting. Should more caution be used in dispensing for such purposes?* *G. Tivis Graves Jr., M.D., Nashville, Tenn.*

Answer.—For none of the operations mentioned may benzene and carbon tetrachloride be regarded as commendable. Both are highly toxic, and both evaporate with ease. The applications stated ordinarily afford large surfaces for ready evaporation, thus adding to jeopardy. Assuming exposure of several workmen on a continuing basis and in the absence of protection, serious poisoning becomes prospective. The simplest safeguard may be found in the substitution of less harmful agents Most tapes may be removed by high flash naphtha. If much metal is to be degreased, this should be conducted in vapor-free degreasing tanks employing trichlorethylene, less toxic than carbon tetrachloride but still toxic. Depending on the definition of "lubrication," it may be stated that ordinarily carbon tetrachloride is a poor lubricant. The processes indicated (excepting silicone use) were briefly popular near the midperiod of World War II. Nearly all manufacturers abandoned these risky chemicals because of actual occupational diseases. The experience of other manufacturers should serve as a deterrent to further use at the present time in the absence of known adequate protection.

FRACTURE OF VERTEBRA

To the Editor:—*My query concerns the use of pituitary adrenocorticotropic hormone (ACTH) in rheumatoid arthritis. A 63 year old white woman apparently had a correct diagnosis and good initial response to the drug; later a pathological fracture of the first lumbar vertebra developed. The roentgenogram of the lower part of the spine showed osteoporosis. Would resumption of treatment with either ACTH or cortisone cause a tendency toward more fractures?*

Thomas C. Lawford, M.D., Hilton Village, Va.

Answer.—Neither pituitary adrenocorticotropic hormone nor cortisone in moderate maintenance doses predisposes to spontaneous fractures. Resumption of ACTH, 40 mg. in 24 hours (divided doses), or cortisone, 300 to 400 mg. weekly (divided doses), should offer no hazard, provided there are no other evidences of toxicity. Senile osteoporosis, which may well be the cause of the fracture, should, however, be treated by means of combined androgen and estrogen therapy.

AMPHETAMINE AND NARCOTICS

To the Editor:—*A 52 year old nurse complains of backache, gallbladder and other pains, for which I found no basis. She has requested prescriptions for amphetamine sulfate. She had previously taken narcotics for six months. As long as she takes amphetamine (10 mg. three times daily) she has no desire for narcotics. Kindly advise me as to the management of this problem.*

Henry Bachman, M.D., Malta, Ohio.

Answer.—The chronic use of 10 mg. of amphetamine sulfate three times daily should not produce any untoward symptoms other than mild depression of appetite and slight insomnia. Despite this, use of the drug should be discontinued since the general tendency of addicts is to increase the dose of any drug until undesirable symptoms do appear. Chronic use of amphetamine frequently leads to experimentation with other drugs and may, therefore, result in a more serious addiction. It is not unusual to find patients who use large amounts of barbiturates and amphetamine concomitantly. They find that the amphetamine makes them extremely nervous and attempt to counterbalance this with barbiturates. The barbiturates produce excessive sedation, so more amphetamine is taken and a vicious circle is begun. Since no physical basis for the patient's complaints exists, it appears likely that use of amphetamine is a symptom of an emotional disorder. She should be referred to a psychiatrist.

PURPURIC MANIFESTATIONS

To the Editor:—*A white woman, aged 54, has been feeling poorly since the death of her husband, five years ago. Two years ago, after moving into an apartment over a funeral parlor, she developed a hypochromic normocytic anemia that persisted despite liver, iron, folic acid, and vitamin B_{12} therapy. Six months ago purpura and melena developed. Fragility, bleeding time, coagulation time, sternal marrow, blood chemistry and urine were normal. The only two pertinent findings were a positive tourniquet test and a thrombocyte count ranging between 90,000 and 225,000. The epinephrine test (Doan) elicited a positive response. On the basis of this, the spleen was removed. After the splenectomy, there was extremely active erythropoiesis as evidenced by many nucleated red blood cells in the peripheral blood and an increase in the cellular elements. However, the red blood cells have not attained a level above 4,000,000, the white blood cells above 5,000 and the thrombocytes above 250,000 except in the week following operation. Now, two months after splenectomy, she has begun to show petechiae again and hematuria, despite a thrombocyte count of 250,000. Could the chemicals used in mortuaries (formaldehyde, etc.) be the cause of this condition? The patient has complained of irritating odors in her apartment.*

Herman Fischer, M.D., Clarksburg, W. Va.

Answer.—The toxic effects of formaldehyde are usually manifested by burning of the eyes, lacrimation and irritation of the air passages. Anorexia, sleeplessness, weakness and palpitation of the heart are other effects. Hematopoiesis is not affected except after excessive and direct exposure. The other substances now used in embalming are not toxic for the hematopoietic system.

The data presented suggest that the purpuric manifestations are the result of increased permeability of blood vessels rather than of thrombocyte deficiency. It is suggested that subacute bacterial endocarditis, pelvic tumor and allergy be ruled out as possible causes. The capillary permeability might be reduced by the use of hesperidin or rutin, together with large doses of ascorbic acid.

ELECTRIC SHOCK

To the Editor:—*A 36 year old electrician suffered an electric shock in December 1949 which made him unconscious for several minutes. In the next month he lost 20 pounds (9 Kg.); he has complained about a weak chest and low back pain since then. The current entered his left hand and emerged through his left foot, burning the bottom of his foot and his finger tips. Roentgenograms of his chest and spine have been normal. Is there any physiological explanation for these complaints? Provided there is some basis for his complaints, what can be expected in the future?*

Lloyd L. Downing, M.D., Ballinger, Texas.

Answer.—Any or all of the muscles lying in the path of the current may have been stimulated to violent contraction at the time that the shock was sustained. It is possible that a certain amount of damage to ligaments and even to tendons was sustained incident to such convulsive muscular contraction. On the basis of the information provided in the letter of inquiry, it is impossible for one to form an opinion as to whether the low back pain may have been caused or contributed to by such electrically induced muscular contractions. An adequate neuromuscular examination of the patient should clarify this. There is no reason for one to believe that the weight loss or the complaint of "a weak chest" is etiologically related to the electric shock.

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JOURNALS ABSTRACTED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT, JANUARY-APRIL 1951

Titles have been listed or abstracts made of important articles in the following journals in the Current Literature Department of THE JOURNAL during the past four months. Any of the journals, except those starred, will be lent by THE JOURNAL to subscribers in Continental United States and Canada and to members of the American Medical Association for a period not exceeding five days. Three journals may be borrowed at a time. No journals are available prior to 1940. Requests for periodicals should be addressed to the Library of the American Medical Association and should be accompanied by stamps to cover postage (6 cents if one and 18 cents if three periodicals are requested). Thus most of these journals are accessible to the general practitioner.

*A. M. A. American Journal of Diseases of Children. Chicago.
*A. M. A. Archives of Dermatology and Syphilology. Chicago.
*A. M. A. Archives of Industrial Hygiene and Occupational Medicine. Chicago.
*A. M. A. Archives of Internal Medicine. Chicago.
*A. M. A. Archives of Neurology and Psychiatry. Chicago.
*A. M. A. Archives of Ophthalmology. Chicago.
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SUBJECT INDEX

This is an index to all the reading matter in THE JOURNAL. In the Current Medical Literature Department only the articles which have been abstracted are indexed.

The letters used to explain in which department the matter indexed appears are as follows: "BI," Bureau of Investigation; "E," Editorial; "C," Correspondence; "ab," abstracts; the asterisk (*) indicates an original article in THE JOURNAL.

This is a subject index and one should, therefore, look for the subject word, with the following exceptions: "Book Notices," "Deaths," "Medicolegal Abstracts" and "Societies" are indexed under these titles at the end of the letters "B," "D," "M," and "S." Matter pertaining to the Association is indexed under "American Medical Association." The name of the author, in brackets, follows the subject entry.

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Acad.—Academy
Am.—American
A.—Association
Coll.—College
Commn.—Commission
Comm.—Committee
Conf.—Conference
Cong.—Congress
Dist.—District
Div.—Division
Found.—Foundation
Hosp.—Hospital
Indust.—Industrial
Inst.—Institute
Internat.—International
M.—Medical
Med.—Medicine
Nat.—National
Pharm.—Pharmaceutical
Phys.—Physicians
Soc.—Society
Surg.—Surgery
Surgs.—Surgeons
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